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HOW many hospitals

are stagnating because the boards of trustees are smug and self-satisfied? How many institutions are falling behind the scientific procession because of trustee inattention? In how many communities is the position of the voluntary hospital actually jeopardized because hospital trustees, individually and collectively, do not aggressively put these hospitals in a position of undoubted leadership?

If the trustees are self-satisfied, uninterested and uninformed about hospital matters, the administrator should immediately examine his own activities and relations to the board. Some administrators choose the easy way. They present formal and uninteresting reports to the board when required by the calendar. They make no effort to keep the board informed of the major movements sweeping through the hospital field. They try to insulate the board from all hospital problems—to "protect" them from worry.

Such a procedure is short-sighted indeed. The figurehead trustee brings no strength to the hospital. Only when trustees are interested, informed and creative in their attitude toward the hospital is the institution and the field as a whole receiving its best service from them. And such trustees need not be "snoopers." Properly informed, they will understand that there are plenty of problems of policy and development to absorb all of the time they can give to the hospital. They won't try to usurp the administration. This is the "hard" way, perhaps, for the administrator—but in the long run it is the productive way.

As a beginning take the suggestions outlined by Mr. Sloan in the article on "In the Trustee Lies Our Strength," appearing on page 48. At

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the end of twelve months, see if you haven't a more interested, active and creative board. From time to time we will provide you with more material for trustee education.

WHAT does a hospital think of the flat-rate or inclusive-rate plan after five years' experience? Next month F. V. Altwater of Duke Hospital, Durham, N. C., will appraise this method.

HOSPITAL architecture in Australia has a very modern appearance. We've picked out several of the best examples of this newer architecture to present to you during the next few months. The first will appear in the December issue. The plans incorporate the idea of doctors' offices in the hospital—an important departure that also is gaining considerable headway in this country.

YOU may soon run up against the question of subcutaneous oxygen administration. There is much interest in it today so we asked Dr. M. Herbert Barker of Passavant Hospital and Northwestern University to outline and evaluate the method for hospital administrators. This he will do in our December issue.

AN ARTICLE of special value to hospitals in small towns will appear next month from the pen of Dr. A. F. Branton, who runs an excellent little hospital in Willmar, Minn., at the same time carrying on a heavy medical practice. Doctor Branton is most constructive in his approach to the problems of the small town hospital.

AT LAST the American Medical Association and the American Hospital Association are close together on an important subject. The December issue will demonstrate this convergence of ideas by a striking comparison.

WHAT is good lighting for patients' accommodations? A qualified illuminating engineer will present next month the results of careful studies of the subject.

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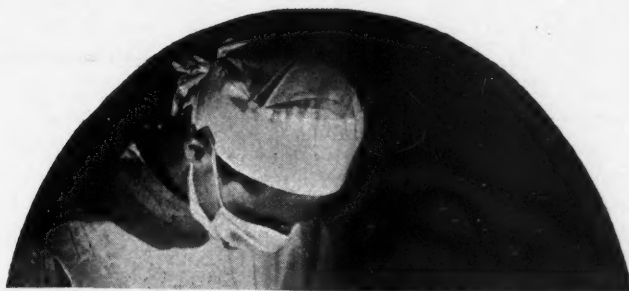
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SQUIBB ETHER

THE U. S. Public Health Service has, as most administrators know, been conducting an extensive survey of hospital and clinic service in the United States. Some of this material is now ready for publication and next month we shall present the first of two articles on clinic service by Margaret Lovell Plumley. This article will deal with the income and expenditures of clinics.

FLASHES FROM THIS ISSUE:

"The dawn of a new era, bringing with it an awakening of social obligations heretofore never realized, is transforming hospital stewardship from an empty gesture into a definite job." Page 48.

"Doctors and nurse anesthetists should throw aside any differences they may have and cooperate on mutual ground for the advancement of the whole field of medical science." Page 51.

"The buyer should know as thoroughly as possible the character and the particular uses of the articles he handles and their importance to the hospital." Page 60.

"If sufficient flexibility in schedules of service is put into plans and costs, and rates are gauged accurately, there is no more reason why group hospitalization should be a class proposition than that life insurance should be a class proposition." Page 62.

"The preparation of the hypodermic tray and the practice of the proper technique in giving drugs subcutaneously are very common and yet are most important procedures." Page 67.

"Every city of 50,000 or more population needs a nursing home sufficiently well organized and managed so that it can be recognized and accepted by the medical profession." Page 72.

"Massachusetts was the first state in the United States to appropriate funds from the state treasury for the purchase and maintenance of a hospital to be used solely for the diagnosis and treatment of cancer." Page 76.

"The medical librarian should possess originality and initiative and should be alert to all new ways of improving medical records." Page 79.

"In training workers adequate instruction must be given in a manner suited to the individual." Page 90.

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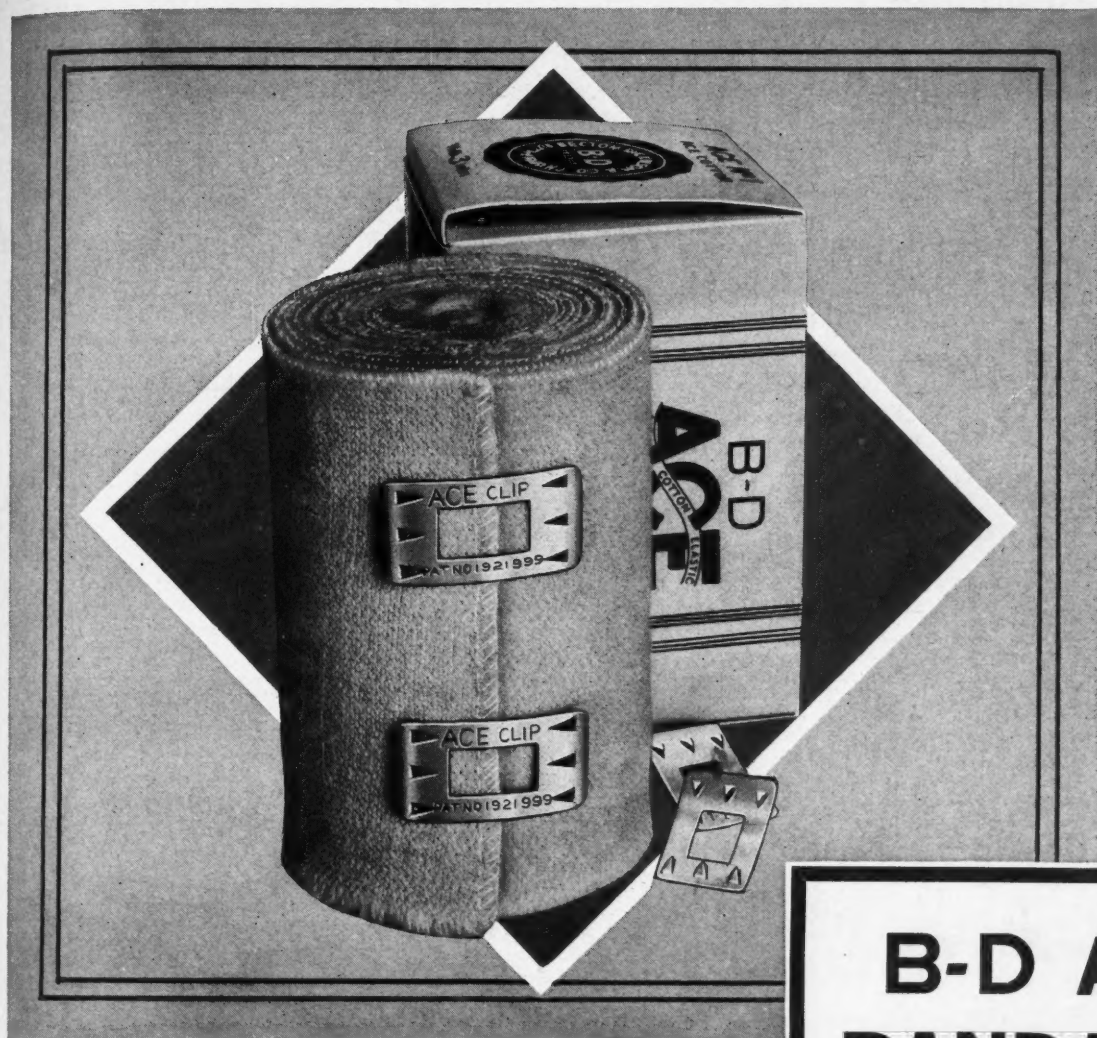
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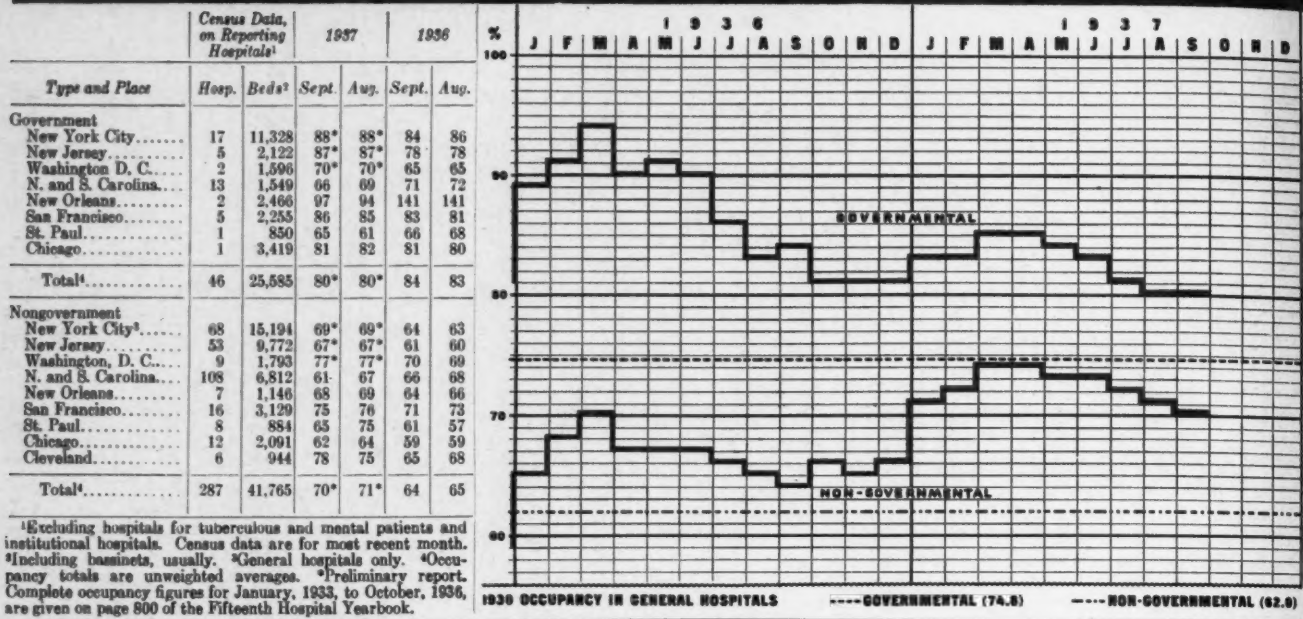
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HOSPITAL OCCUPANCY BAROMETER



September Occupancy Drops as Usual

The usual seasonal drop in occupancy was recorded for the voluntary hospitals in September and corrected figures brought down the August figures also. In spite of these drops, however, the August and September occupancies were each six points above the corresponding figures for 1936 and eleven points above the corresponding figures for 1935.

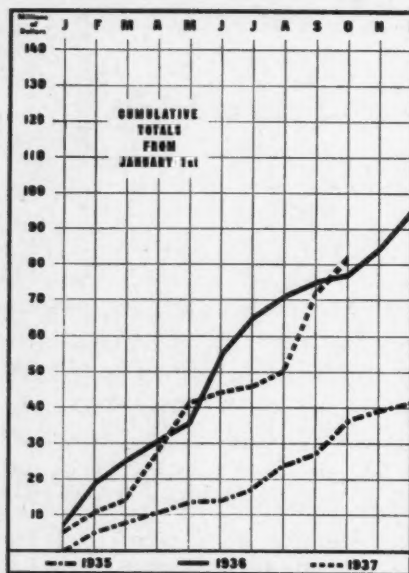
In the government hospitals occupancy remained at 80 per cent, the lowest occupancy that has been recorded for these institutions during the last five years.

The principal drops in occupancy of voluntary hospitals were reported from St. Paul and the Carolinas. An increase was reported from Cleveland. There were no large changes in the occupancy of the government institutions.

Hospital construction took a spurt in the period from September 13 to October 25. Sixty-six new projects were reported involving a total of \$9,927,000. This brings the total for 1937 to date to \$81,670,000, a sum nearly \$4,000,000 larger than had been reported by this time last year and \$45,000,000 ahead of 1935 at this period.

The sixty-six projects reported during the reporting period were nearly all additions to existing hospitals. There were 49 additions of which 47 reported costs of \$7,943,500. Eleven

HOSPITAL CONSTRUCTION



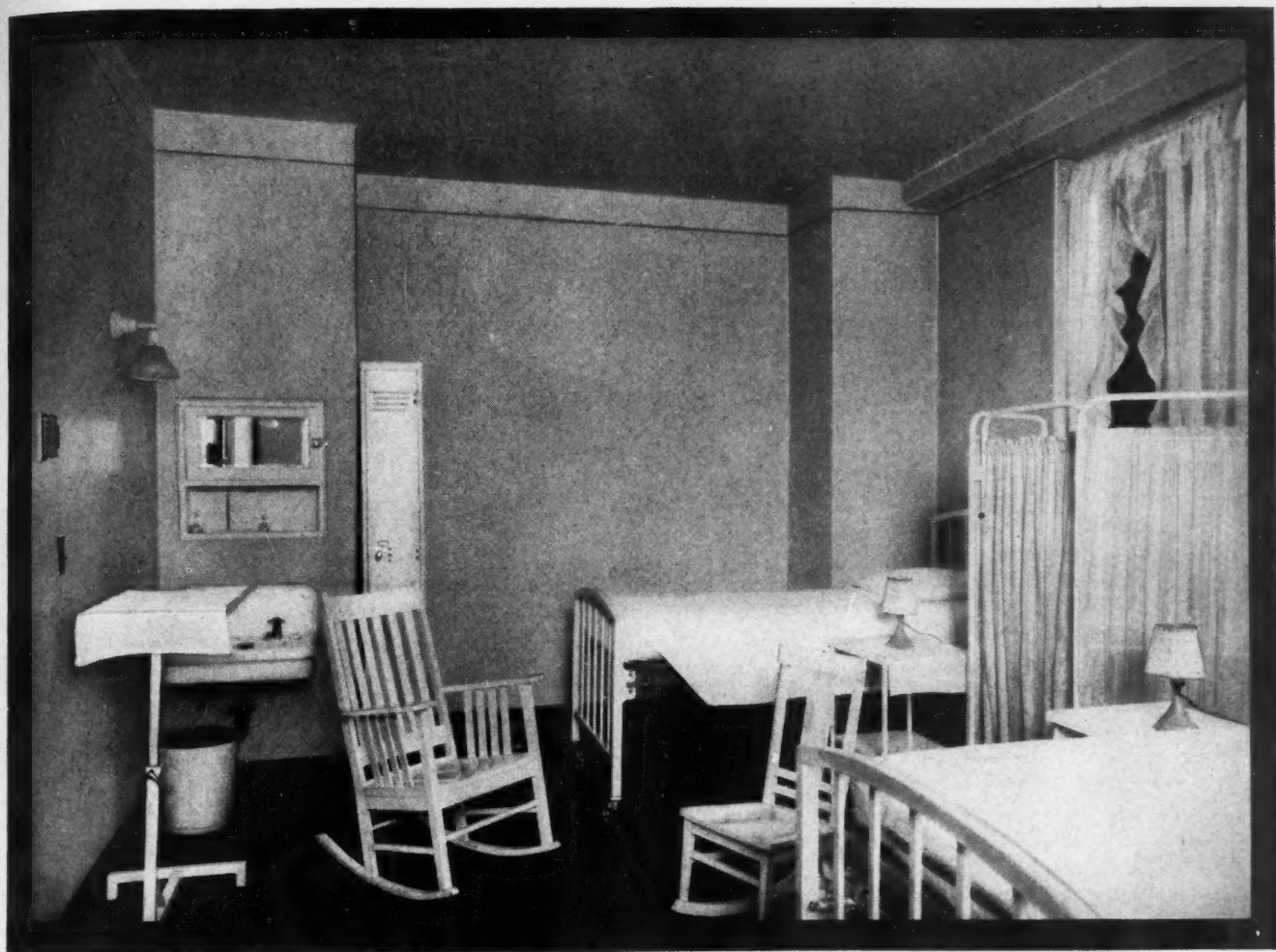
new hospitals were reported which will cost \$1,557,000, three alterations to cost \$525,000 and three nurses' homes costing \$304,343.

In spite of the gyrations of the stock market, the general wholesale price index of the *New York Journal of Commerce* did not show great instability, dropping from 90.4 on September 20 to 86.1 on October 18. Grain prices

during the same period dropped rapidly, the index going from 96.4 to 80.1. The total extent of this drop may be realized by comparison with the grain price index number on July 17, which stood at 114.8.

Other food prices meanwhile rose enough to more than offset the price of grain, lifting the general food price index from 83.9 on September 27 to 86.7 on October 18. Textile prices continued their slow decline, dropping from 64.8 on September 20 to 62.0 on October 18. During the same period building materials dropped from 102.5 to 99.3 and fuel prices remained unchanged. The price of drugs and fine chemicals as reflected in the index of the *Oil, Paint and Drug Reporter* showed no appreciable change during the period under review.

Improvement in the economic status of wage earners has been greater in manufacturing industries than in non-manufacturing industries, according to an analysis by the National Industrial Conference Board. "Real" weekly earnings, which take into account changes in living costs, are 9.5 per cent above the 1929 level in manufacturing industry but 0.4 per cent less in nonmanufacturing industries, the board reported. Manufacturing payrolls are 4.9 per cent below 1929 while pay rolls in nonmanufacturing industries are still 26.5 per cent under the 1929 average.



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The Editor Talks It Over

Hospitals Preferred

• It is said that "tempus fugit" but time and change creates no greater effect anywhere than upon the hospital and its policies. Senator Moore, speaking at the dinner of the American Hospital Association at Atlantic City, N. J., remarked that no longer can all truthfully say with Thomas Hood, "I remember, I remember, the house where I was born; the little window where the sun came peeping in at morn." An ever-increasing number must paraphrase Hood's famous poem by remembering not the house where they were born but the maternity ward in which they first saw light.

This era of apartment houses has created an inappropriate site for the conduct of a delivery. There is more, however, than mere physical change in ways of living. The hospital is becoming ever more popular as a safe and comfortable place for the pregnant woman. In many cities the number of hospital deliveries is approaching or passing the 50 per cent mark.

Pleasant Parting

• It is good hospital practice never to allow anyone to leave dissatisfied with the treatment received. It may not be possible always to soothe the feelings of those who believe that they have a grievance. The attitude of the administrator toward those who make complaints is really the key to the situation. If he assumes the position that the hospital is always right, that the mistakes as reported could not have occurred, that the complainer is unfair in his strictures of the hospital's work, the administrator is likely to add fuel to the flame and thus decrease rather than increase community respect for the institution.

To create the feeling among the hospital's clientele that constructive criticism is always welcome and that the door of the executive's office is never closed to anyone no matter what his complaint, is much more logical. No matter how unreasonable or petty the person; this attitude is a real chal-

lenge to the administrator's reserve supply of tact and understanding of the vagaries of human nature as displayed by the average patient's relatives.

It is not visionary, therefore, for the hospital to adopt a rule that it will never permit complaints to remain uninvestigated or allow dissatisfaction on the part of anyone without a strenuous effort being made to satisfy both the patient and his relatives.

Thwarting the Weather

• The north wind will soon be forcing its icy fingers through the crevices of the sash and doors of the hospital, bringing discomfort to patients and an increase of fuel expense. Now is the time to thwart this coal pile marauder by setting institutional carpenters at work installing weather stripping, making basement windows tight and closing every exit for expensive heat. Incidentally, it might also be wise to make certain that hospital plumbing is in readiness to withstand the freezing and thawing of winter and that eaves pipes and galvanized uprights are clear and open. Fall leaves also have a way of producing disastrous effects by blocking outdoor drains, which, coupled with later freezing, brings unnecessary expense.

An Ever-Present Help

• Hospitals have a way of meeting emergencies that has served to build a fine tradition of readiness to spring into action on the shortest notice. One recalls the problem that was presented to the two hospitals in Philadelphia in 1775 when a large number of French neutrals, the so-called Acadians, descended on that town and tarried there for a number of months in their migration to the South. At that time these two struggling institutions were called upon to treat a large number of these dependents. Food was scarce and the city was

forced to send criers into the immigrant colony announcing the formation of bread lines.

It was no small task which confronted the Philadelphia Almshouse and Hospital on a winter's day in 1777 when it was notified by General Howe, the British commander who had taken control of the city, that the institution must be vacated on short notice to make room for housing the ailing soldiers. This move was made, and even though a smaller number of soldiers returned within a few months, the city again being under Colonial control, this hospital functioned during these trying times, housed temporarily in a Quaker meeting house and a Masonic hall.

In similar fashion the recent devastating floods in the South failed to dampen the initiative and the spirit of those who were conducting hospitals there, the work being carried on with surprising efficiency under most distressing circumstances.

Dreamers and Doers

• Imagination is the parent of the phonograph, the telephone, the airplane and all the modern conveniences of hospitals. The field of hospital administration is not a humdrum slough of routine—at least it should not be—and there is much in it to stimulate the imagination to better accomplishment and higher ideals. Imagination, directed into proper channels, will improve the atmosphere of the hospital field, will build more and better hospitals and will give to the public more and better service.

We need more men and women with bigger, broader and more active imaginations, people who are able to dream dreams and who have the courage and tenacity of purpose to make their imaginings a reality.

New ideas are nothing in the world but new imaginings. They should be encouraged and every employee who has a new thought for the improvement of the hospital and its work should be commended and rewarded.

Looking Forward

The Employee's Demands

ELSEWHERE in this issue (page 118) appears a letter from the acting president and a member of the United Hospital Workers of Chicago. This letter sets forth the point of view and goals of this organization and the method of procedure that it intends to follow.

In brief, the demands of the union are for recognition, minimum wages of \$75 per month (with proper deductions for maintenance), a forty-four-hour week and two weeks' vacation with pay. Union members propose to achieve these objectives through negotiations leading, in case of a deadlock, to arbitration. They express fundamental opposition to a strike in a hospital but if the hospitals refuse point-blank to negotiate and arbitrate, the union may consider using the strike as a last resort.

Disregarding certain overstatements and, perhaps, faulty reasoning, one may nevertheless commend the union for its willingness to use negotiation and arbitration to settle disputes. With an intelligent, fair arbiter this is the orderly and economical method of settling such difficulties. If the acting president had stopped here, his case would have been a strong one.

However, he went further. He stated that "we do not believe it will ever be necessary to call a strike, but if it should be necessary, strike plans will be analyzed by competent medical men and hospital experts in order to avoid seriously involving anyone innocent of our controversy, particularly patients."

One may reasonably doubt whether any medical and hospital experts could draw a tortuous line separating those persons in the hospital whose service is not essential to patients from those who are urgently needed. The fabric of hospital service is closely interwoven and the warp cannot be separated from the woof without destroying the strength of the whole cloth.

Surely there are other means by which em-

ployees, if they have just cause, can obtain fair consideration without a strike!

The union would be in a stronger position if it abandoned the strike technique entirely and appealed to the sense of fair play of hospital administrators, hospital trustees and the public. Hospital authorities that are wise will not make the mistake of assuming an antagonistic attitude. They will carry on negotiations, if these are conducted in a spirit of mutual respect and confidence. To the full limits of their ability, they will do what is fair to their employees. Furthermore, their manner of doing it will win rather than alienate the respect and confidence of employees and the public.

"C. C. M. C."—Five Years After

NOV. 29, 1937, will mark five years since "Medical Care for the American People," the final report of the Committee on the Costs of Medical Care, was given to the public. What has happened since then? What effects upon the hospital field, if any, can be attributed to those studies?

The twenty-six volumes of factual studies issued by the committee, the summary volume of these findings, and especially the final report with recommendations, secured widespread national publicity. The attacks upon the committee's reports undoubtedly enhanced public interest in them. In the innumerable articles, discussions, debates, forums and radio addresses on the economics of medical care during the last five years, it is rare that reference is not found to the committee's work.

The committee's studies on the incidence and costs of sickness have been followed up since 1932 by such agencies as the Metropolitan Life Insurance Company, the medical societies of Michigan and California, the relief administrations of several states, the Milbank Memorial Fund, and the U. S. Public Health Service. The

need of a large proportion of the population for more medical care and the uneven and burdensome incidence of sickness costs have received continued confirmation. Studying the problems of medical care instead of merely arguing about them is now becoming a habit among both medical and lay organizations, however diverse their objectives or methods.

The committee's recommendations featured the future importance of group medical practice and the hospital as the organizing center of medical service. The report of the American Foundation last spring showed that many leading physicians throughout the United States now accept these principles.

Another important recommendation of the committee was "the distribution of the costs of medical care over groups of people and over a period of time, through taxation or insurance." Since 1932, tax-supported medical care has substantially increased. This was largely due to the depression, along with the advent of a new national administration. Public responsibility for sickness has been extended in many communities for persons on relief and often for other persons unable to pay for needed care. The use of public funds to meet the cost of hospital service in both government and voluntary institutions has been enlarged in many localities as an outgrowth of this general change. Public health work also has been advanced greatly. All these policies* were among the committee's recommendations.

The majority of the committee recommended "voluntary hospital insurance." Within three months after the appearance of the committee's report, the trustees of the American Hospital Association approved this principle and set under way "group hospitalization" on a community basis. Today, a million people are beneficiaries. The committee's findings, that family expenditures for hospitalized illness constitute on the average about 50 per cent of their expenditures for medical care, and that about 40 per cent of these costs are presented by the hospital's own bill, have furnished valuable ammunition for the organizers of hospital insurance in many cities.

Despite or perhaps because of the depression, the plans of voluntary health insurance in industry and under the auspices of medical groups have shown unusual stability and today more new plans appear to be under discussion than at any previous period. Again the committee's reports furnish material to which those interested in these movements turn for information.

Changes in hospital service and medical care during the last five years are, of course, attributable to many influences: local and national, eco-

nomic and political, as well as medical. Among these causes stand out the findings and recommendations of the Committee on the Costs of Medical Care.

A. H. A. Reorganization

THE thirty-ninth annual convention of the American Hospital Association changed the whole fabric of its administrative set-up into a more effective and modern garment. The council of the American Hospital Association, suggested a few years ago by Dr. S. S. Goldwater, had shown the possibilities and usefulness of a small study group. It was the work of the subcommittees of this council, expanding as time passed, that pointed the way to six bodies instead of one body.

The splendid personnel of the new councils selected at the Atlantic City meeting gives high promise of fruitful work in the interest of hospitals. The American Hospital Association, in this field of its activity, should achieve greater accomplishments in the interests of the sick.

The Roentgenologist Objects

FREQUENTLY in organizing hospital care insurance plans the leaders have encountered more or less rigid opposition to the scheme from various members of the hospital specialty group, roentgenologists in particular. This resistance has been so stubborn that here and there plans have been delayed in development or indefinitely postponed.

A glance at the arguments advanced reveals, first, the contention that the hospital has no moral right to sell the physicians' services. This statement is far from convincing. Every x-ray specialist who shares with the hospital, on a percentage basis, the income of his department is selling his services.

Every institution in the United States that operates with a full-time salaried staff (and in this class are some of the nation's finest general hospitals) sells the services of physicians. Even a purely voluntary staff, which cares for ward patients and at the same time uses operating rooms and clinical laboratories in treating private patients, is a part of a plan that sells the services of the doctor.

It is no more nor no less ethical to sell these services to hospital insurance patients than it is to provide them for other hospital patients.

Next, it is claimed that the principle of hospital care insurance, if followed to its logical conclusion, leads surely to socialized medicine.

Nothing can be farther from the truth. That the demand of the day is less expensive hospital care of the sick cannot be denied. Many feel that this can be obtained only by government control of hospitals and physicians. But the group plan, by lowering the cost of illness to the individual, is the surest buffer against government usurpation of the privileges both of the doctor and the hospital.

There has not been the least tendency to include in group fees the cost of medical care given by the patient's privately selected physician. Some plans specifically exclude patients who do not pay the doctor's bill from hospital care insurance benefits.

The real fly in the ointment which underlies this opposition appears to be a suspicion that the plan is proposed to deprive the doctor of his rights and to drive a wedge between him and his patient. This is not the case and it is highly probable that the incomes of both the specialist and the general practitioner will be increased by the adoption of the principles of group hospitalization.

If certain specialists wish to quarrel with hospitals because present relations are unsatisfactory to them—and there is legitimate doubt whether this is true of a majority of radiologists and pathologists—let them come out into the open about it. Hospital care insurance should not be used as a cat's-paw. It did not create these relations. It merely adopted what it found and will change when the hospitals change.

Intramural Graduate Activities

STAFF activities of the hospital sometimes appear to be conducted on a secretly guarded basis. The ophthalmologist goes industriously on his way examining eye grounds, refracting and occasionally extracting a cataractous lens. The laryngologist, the bronchoscopist, the obstetrician, the neurologist, the intern and the surgeon singly perform their daily toil. Each knows little of the problems confronting the others.

The general practitioner is endeavoring efficiently to practice a combination of many specialties. He is receiving little help from the major staff of the hospital in which he may have interned and to which he now sends patients. Sometimes the staff man hesitates to teach juniors from a purely selfish motive, but no man of major calibre will be guilty of this attitude.

Here and there this problem is being met by postgraduate practical demonstrations to younger physicians in the commoner specialty conditions met in practice. Each staff may share

in this effort. Classes are kept small and registration is required. This plan is commended to hospitals as one which may be extended later to community doctors who are not on the staff. It offers fruitful possibilities for improving scientific care of the patients.

Group Plans to Be Approved

AN EXCEEDINGLY significant move was made at the recent Atlantic City session when the committee on hospital service decided to set up standards for group hospitalization plans and, in conjunction with the advisory committee on group hospitalization, to approve those plans which meet the standards.

There have been standards, of course, since early in 1933 when the council on community relations and administrative practice approved the basic idea of hospital insurance and promulgated general principles to govern plans. But until now no formal attempt has been made to separate the good plans from those that are on the borderline or across it.

Public confidence, as well as the confidence of the medical profession, now can be given in full measure to those plans that receive the official "O. K." of the committee on hospital service.

A Good Combination

HOSPITALS associated with or comprising part of a medical college are not always ideally administered. Often the superintendent of this institution is curative and preventive-minded to a degree that blinds him to the educational viewpoint of the dean of the college. This variance of ideals often leads two splendid individuals into unpleasant relations, harmful to both college and hospital.

A combination of the duties of hospital and medical college executive in one person is sometimes an effective step. A qualified man is hard to find. He may either be ruthless in his educational approach to patients and lacking in an understanding of the hospital complexities, or he may possess no educational vision, and, hence, view the teaching angle of institutional work as a nonimportant by-product which must be tolerated.

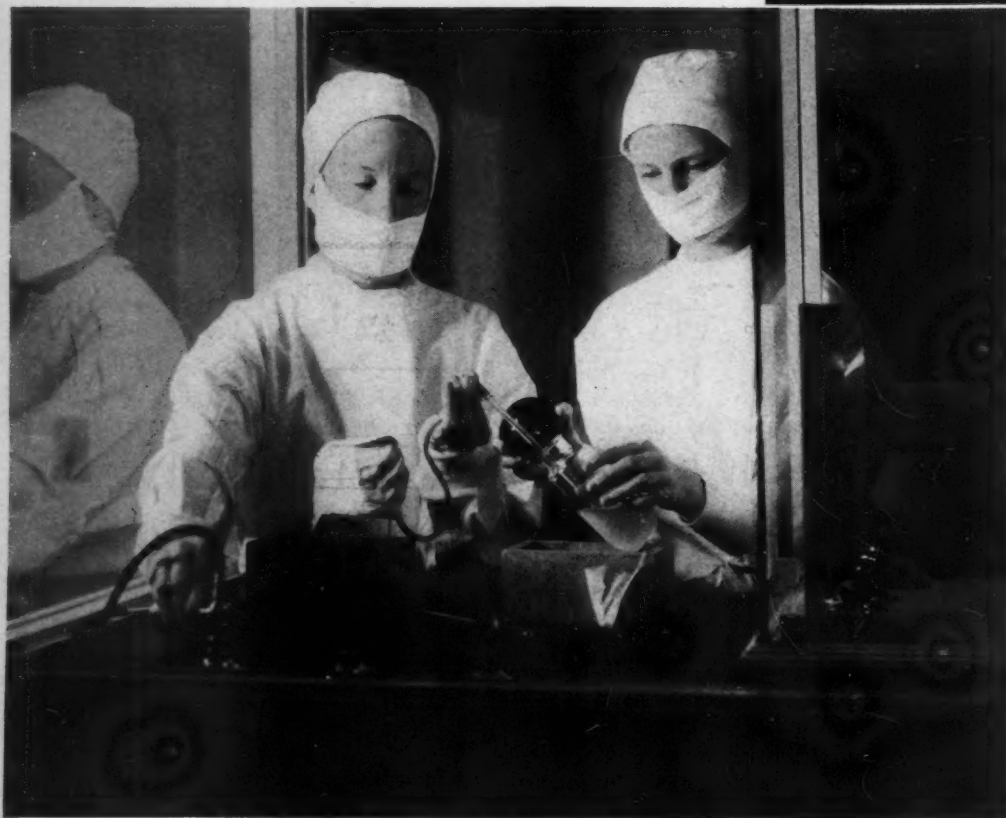
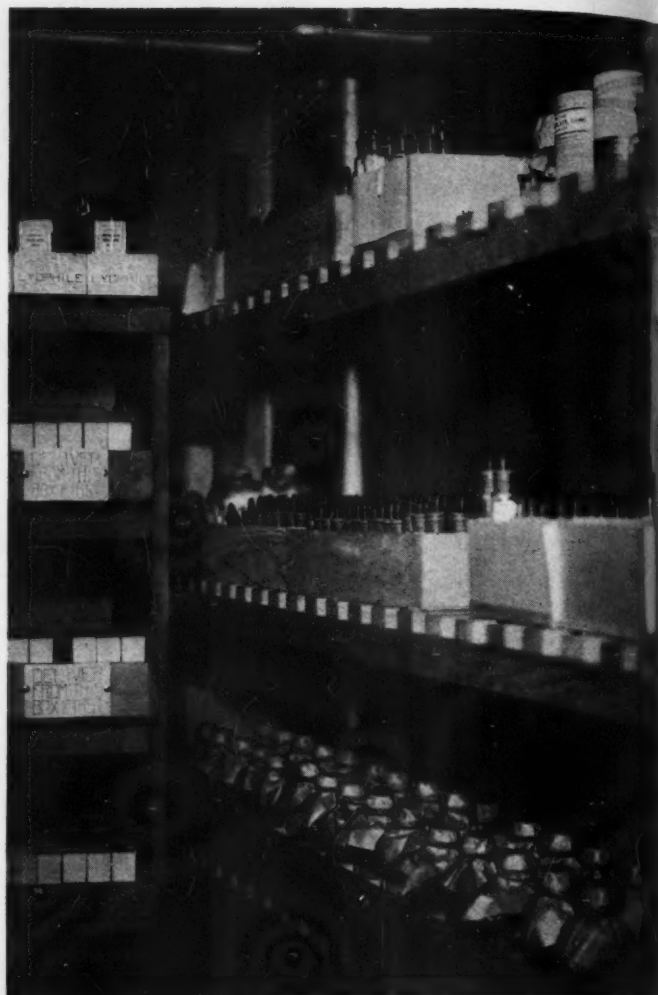
When a man is found whose particular administrative abilities can encompass the complicated problems of preventive, curative and educational work, a *rara avis* indeed has been discovered. Then this type of set-up in directing the medical school and its laboratory, the hospital, is direct, sound and to be recommended.

Serum Center

By CLARENCE M. HYLAND, M.D.

THE rôle of human convalescent serum has been steadily gaining a more important place in the fields of both preventive and therapeutic medicine. Cognizance of this fact has led to the establishment of a convalescent serum center in the Children's Hospital in Los Angeles. It was organized with the twofold purpose of making readily available to physicians those convalescent serums that experience has proved are a valuable aid in the prevention and treatment of certain contagious diseases, and of providing facilities and opportunity for research into the widening field of serum therapy.

With these purposes in mind, the serum center is organized and operated immediately under the



Laboratory technicians are engaged in drawing off convalescent serum. This process is repeated until the serum finally obtained is a clear, light amber fluid.

Take a peep inside the refrigerating room at the convalescent serum center at the Children's Hospital, Los Angeles. Here are seen vials of dried serum, stored away until such time as there may be need for them, as well as liquid serum available for immediate use.

supervision of the director of laboratories of the hospital. It is provided with its own personnel and plant and constitutes a unit entirely distinct from the clinical laboratories. In addition to the director, three technicians, a secretary and a diener carry on the work of the center. The plant includes rooms designed for making up and sterilizing the equipment, for bleeding the donors and for processing, refrigerating and dispensing the serum.

The serum center is in no sense a profit-making institution. The initial investment is necessarily large and in this center the money was donated by members of the hospital board, various auxiliaries of the hospital and other individuals interested in making a contribution to the welfare of their community. The income resulting from serum sales up to the present time has been no more than adequate to meet the running expenses of the center, such as payment of the donors according to a scale standard in the community, payment of salaries of the personnel, and purchase of supplies and equipment. Any surplus remaining after these expenses have been met is used to provide serum for those unable to pay and to assist in the maintenance of the center's research section.

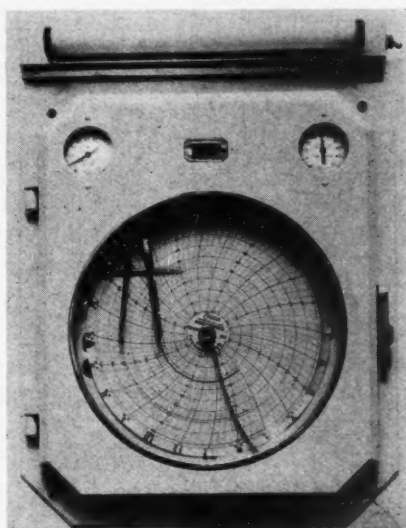
Since measles and scarlet fever serums are the most widely used of all human convalescent serums and are of firmly established value, it is natural that these two comprise the bulk of the serum processed and dispensed by the center. However, in addition to these, there are always available to physicians a supply of poliomyelitis, mumps, chicken pox, whooping cough, and normal human serums.

Obviously the obtaining of an adequate supply of convalescent human blood is so essential to the operation of a serum center that it presents one of the major problems in the organization of an establishment such as this. Individuals who have recovered recently from the various contagious diseases constitute the group of donors.

After the consent of the personal physician has been procured, the prospective donors are approached and the proposition is made to them. If they indicate their willingness to sell a small quantity of their blood for a designated fee, they are given an appointment and instructed to present themselves at the serum center in a fasting condition, since loss from lipemic blood would otherwise be too great.

If personal history and physical examination indicate that the prospective donor has no disease transmissible by blood transfusion, there is withdrawn from an arm vein approximately 200 cc. of blood, approved aseptic technique being used. This blood is drawn directly into a specially designed "bleeding" set, which consists of a 250-cc. centrifuge bottle equipped with the necessary inlet and outlet tubes. This procedure consumes only a few minutes and is rendered virtually painless by the use of a little novocaine injected into the skin just above the selected vein.

The blood is allowed to remain overnight in a refrigerator which constantly maintains a very low temperature (approximately 2° centigrade).



This instrument is a recording thermometer with a temperature regulating mechanism. One line records the temperature of the incubating room and the other, the exact temperature of the refrigerating room.

Below is a section of the incubating room. Rack upon rack of culture tubes are seen; the thermo-regulator may be seen on the wall in the background.



The following morning the serum is separated from the clot by means of rapid centrifugalization. Next, the serum is drawn off into another sterile centrifuge bottle and the process repeated. The serum finally obtained is a clear, light amber fluid.

After adequate cultures have been made to test the sterility of this product and a small amount has been reserved for the performance of the Wassermann and Kahn tests, the serum is again placed in the refrigerator pending the completion of these tests and the necessity for its use.

When the need arises to complete the processing of the serum to make it ready for use, fifteen or more individual serums, the purity of which has been attested by the results of the aforementioned tests, are pooled together. A small percentage of tricresol is added to the pool as a preservative and the whole is filtered through a Berkefeld filter in order to remove any lipoids or other objectionable material. The serum is then bottled in rubber-capped vials containing the recommended dosages for the different diseases. Cultures for sterility on the pooled serum in bulk and on a certain number of the final containers constitute the last test the serum must pass before it is dispensed.

All the procedures involved in the processing of the serum are carried out in a specially constructed serum room in which all incoming air is filtered to render it free from dust and to reduce to a minimum the danger of bacterial contamination. This center operates under licenses from both the federal and state governments and strictest attention is paid to asepsis at every step in the process. Recording thermometers on the autoclave and hot air sterilizer are valuable aids, in that they leave permanent records of sterilization that may be inspected and checked at any time. Similar recording thermometers constitute a check likewise on the maintenance of proper temperatures in both the incubator and the refrigerator departments.

At the beginning of an epidemic, convalescent serum is hard to get. Therefore, it must be "harvested" toward the end of an epidemic, processed, dehydrated and stored away until it is needed. How this is done and the rôle it plays in disease prevention are told in this article

Although this serum center has been operating only slightly more than a year, enough serum has been dispensed and enough data have been collected through the cooperation of the clinicians using it to yield conclusions corroborative of the work done in similar establishments and of considerable satisfaction to the center itself as an agency interested in public health.

The efficacy of measles convalescent serum as a prophylactic agent has been well recognized for a number of years, the main drawback to its use being the difficulty in obtaining the serum. The establishment in a community of a serum center licensed and equipped to provide a reliable, potent serum eliminates this difficulty.

Has Measles Serum Therapeutic Value?

Although measles is often considered merely a mild disease, necessarily incidental to childhood, it may frequently prove serious, especially in the case of young or debilitated children. By regulation of the size of the dose of convalescent serum and the time of its administration relative to the exposure date, either one of two desired results may be accomplished: (1) complete protection of infants or of children suffering from some other disease by means of the injection of adequate amounts of serum early enough to establish a passive immunity which will protect the child temporarily, or (2) modification of the disease, which is desirable in the case of normal children and which is effected by later injection of the serum with a resultant mild or sero-attenuated measles followed by a permanent immunity.

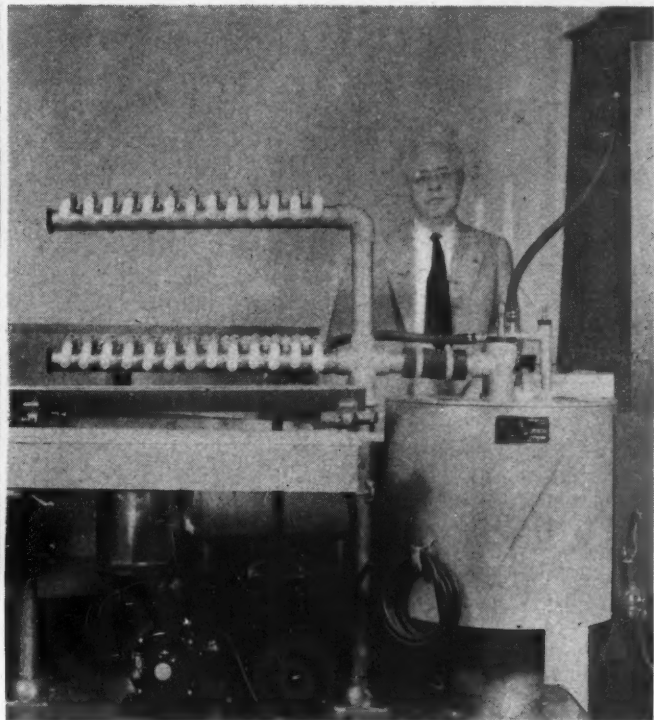
Our experience with the inoculation of 423 home contacts during the spring epidemic of 1936 has been quite in accord with results obtained elsewhere, in that protection or modification was obtained in 97.7 per cent of the cases. Although the use of measles convalescent serum has been limited almost entirely to prophylaxis, in some instances it has been used therapeutically. Our series is much too small to enable us to form any definite conclusions, yet there are indications that the serum may be of some value if given early enough in the disease.

Scarlet fever convalescent serum likewise has been well established for some time as a valuable agent both for the prevention and the treatment of scarlet fever.

In our experimental series of 102 home contacts inoculated prophylactically following definite exposure to the disease, 96 per cent were completely protected. It is interesting to note that of the four cases contracting the disease, three were in one family and had the disease in such a mild form that had there not been a definite history of



"Girls in white" fill ampoules with convalescent serum, while at the right the "lyophile" apparatus used for dehydration of the serum is shown.



exposure the diagnosis of scarlet fever might easily have been overlooked. Convalescent serum was used therapeutically in forty-seven cases of scarlet fever with improvement reported in all except one case. This case was treated with an insufficient quantity of serum. Convalescent serum therapy is valuable not only in that it effects a consistent subsidence in the symptoms of scarlet fever, but also because it causes a marked reduction in the occurrence of the complications that not infrequently follow the disease.

Too small a series of cases have been collected relative to our experience in the use of the other serums to warrant the drawing of any definite conclusions; nevertheless, the results are encouraging enough to stimulate further interest and work in these particular fields.

One of the greatest difficulties with which serum centers have had to contend is the obtaining of an adequate supply of blood at the particular time it is needed. Although it may be possible near the end of an epidemic to have a fairly large reserve of bulk bloods built up, by the time the next epidemic comes, in possibly two or three years' time, this reserve will in all probability have become exhausted or outdated.

A satisfactory solution to this problem is found in the use of a machine known as the Flosdorf-Mudd lyophile apparatus, which takes advantage of the knowledge that serums or other liquids such as milk and fruit juices, when frozen to a very low temperature and dehydrated from the frozen state under a high vacuum, maintain their essential

qualities almost indefinitely. Accordingly, the desired quantity of serum is obtained and processed as usual. It is then bottled in containers which take a vacuum-tight stopper. This serum is frozen rapidly and then brought to a very low temperature (-79°C.) by the utilization of dry ice. At this temperature the containers are attached to the lyophile apparatus and allowed to remain there until the dehydration of the serum has been completed by the action of the vacuum pump. The bottles are then sealed off by means of an oxygen torch in such a manner as to preserve their vacuum. After the necessary cultures for sterility have been made, the vials containing the dried serum are stored in the refrigerator until needed. At this time the addition of sterile distilled water is all that is necessary to restore the serum to a condition closely allied to its former consistency and potency. Thus serum may be "harvested" at an opportune time, processed, dehydrated and stored away until such time as there may be need for it, such as at the beginning of an epidemic when it has not yet been possible to build up a reserve of liquid serum.

That the field of serum therapy offers a fruitful field for research is well known by anyone familiar with this type of work. In this serum center, as in most centers, the actual preparation of convalescent serum for the prevention and alleviation of disease takes precedence over all else. However, it is expected that in the future there will be opportunity to continue the research demanded by the numerous problems arising in this field.

In the Trustee Lies Our

By RAYMOND P. SLOAN

NEVER before has the hospital trustee basked so conspicuously in the limelight of publicity as he is doing today. From the status of figurehead, his name appended to verbose annual reports conscientiously distributed but seldom read, he is fast developing a personality. Sessions of national and state hospital bodies now include programs dedicated to his individual interests. Through printed message and spoken word, he is made aware of his duties, also his shortcomings. Even the plainly discernible trend toward group movements is enlisting his allegiance and there is manifest a tendency to form trustee councils to work for the common good.

The old order changeth, to be sure. Gone are the days when hospital trusteeship was chiefly a mark of distinction—an honor bestowed upon the chosen few—a post that exacted little but gave much in social prestige and civic authority. The dawn of a new era, bringing with it an awakening of social obligations heretofore never realized, is transforming hospital stewardship from an empty gesture into a definite job. In its ultimate realization lies the hope of the voluntary hospital.

What part is the administrator to play in its metamorphosis? With greater educational opportunities at his disposal, will he participate in, inaugurate even, a program for the enlightenment of his trustees? Or, aware of the pitfalls of too great knowledge in the lay mind, will he pursue the even tenor of his way, satisfied to let well enough alone?

That Mysterious Group

The faint-hearted can formulate in imagery all manner of dangers resultant from an enlightened trusteeship. They are there ready to respond to the slightest encouragement, constituting a challenge that may prove embarrassing. On the other hand, what hope is there for institution and executive alike left to shift for themselves without authoritative guidance and intelligent support? What chance of meeting legislative problems, of coping with the labor situation, of aiding the hospital to find its proper place in the public health program?

As individual as are many of the problems that hospitals face, contingent upon the particular type of service they render and the community they

serve, there is one they all share—the board. Always there is that mysterious group seldom seen and generally inarticulate save for the conscientious few who give generously of their time, strength and money. Their meetings held at stated intervals take place behind closed doors, some even outside the hospital, and, what is more difficult to explain, beyond earshot of the administrator. In all fairness it may be said that the latter unbusinesslike practice is gradually being abandoned.

To this group the administrator falls heir. As with his relatives, he has no choice. He has but one logical course of procedure—to win their support and to ascertain in what phase of hospital work their interest naturally lies, then to provide them with the opportunity for developing that interest. It can be done, it has been done and more will do it as they trace its benefits.

How Educate the Trustees?

What tangible evidences of trustee education exist today? The question is a fair one. Its answer lies in actual accomplishment.

There is the hospital in which trustees may be discovered each month studying a specific department. Yes, the old visiting committee plan at work but with a new function—to learn of departmental procedure at first hand. One group of three takes the dietary department, another, the out-patient department, a third, the x-ray and so on. Next year the assignments will be redistributed. Their obligation is not fulfilled after one afternoon of study, however. The succeeding month they follow exactly the same procedure in some other hospital. No report is expected of them until the two trips are completed and notes made.

The assumption is, and to date it has proved correct, that these excursions will form a basis for comparison that will prompt questions and stimulate discussion. Each man eventually gets to know not only his own institution, but others, and is more conscious of hospital problems generally. There is heard no more at least that typical

Strength

An appeal to administrators to develop an educational program for their trustees. The author, himself a hospital board member, traces trends that are leading to an enlightened and articulate directorate

trustee statement handed down from one generation to the next, "In company with Mr. Jones we visited the hospital on Thursday, May 2, at four-thirty in the afternoon, and found everything in excellent condition. The entire building was immaculately clean—a tribute to the efficient management and our staff of zealous workers."

To gain the true significance of the next presentation there should be "before" and "after" glimpses of the board at work. Our first introduction reveals twelve or fifteen men out of a group of forty-five seated in the directors' room of a bank located at least ten miles distant from the hospital. The superintendent is reading a report—a very lengthy report, it seems, and not too entertaining, judging from the far-away expressions on their faces, and the shuffling of feet as they squirm restlessly in their chairs. Certain individuals attempt to divert themselves by following the monotonous recital of figures on the sheet which they hold in their hands.

Board Meeting, New Style

Now for our "after" view. Can this be the same group, comprising some thirty-six gathered around the luncheon table chatting informally across the board? Down at the end the president rises. "Gentlemen, we don't want to take any more of your time than is necessary, and we promised you that this meeting would be over at two o'clock sharp. Our speaker of the day, Mr. John Doe, has graciously consented to raise his voice above the clatter of your plates and give you his interpretation of hospital trusteeship while you finish your dessert and drink your coffee."

This, it seems, is just one of a series of luncheon meetings made interesting and informative through the presence of outside speakers qualified to discuss some phase of hospital work. The subject of group insurance has been covered and other titles already presented or scheduled for future programs are, "Mechanical Problems the Trustee Should Know," "Food as a Builder of Good Will," "The Trustee's Part in Public Re-

lations" and "How the Hospital Views Labor." Either before or after the guest speaker is introduced a brief business session takes place. Reports in detail are mailed to the board members two or three days in advance of the meeting, so only the high spots are touched upon by the superintendent. Round table discussion is invited on any of the points raised and necessary resolutions are passed. It is all done in an hour and a half.

Attendance at these meetings last winter averaged between thirty and thirty-six. They are held at a luncheon club through the courtesy of one of the members, but each man pays his way. Twice a year, too, the trustees meet for dinner at the hospital when entertainment is also provided which is both educational and stimulating.

Perhaps the strangest sight is yet in store for us! In the metropolitan area surrounding one of our large eastern cities, a group of hospital administrators meets regularly. They represent medium-sized hospitals in suburban communities—and are for the most part women. Each month they gather at a member's hospital for dinner and an evening of informal discussion of their mutual problems.

Strange Table-Fellows

The fact that these are far-sighted executives mindful of the challenge in our changing times to voluntary hospitals prompted them to consider carefully the function of their trustees. They realized the dire need for gaining their support and guidance on current problems. To do so meant deliberately soliciting their interest, and familiarizing them with the problems of hospital routine.

It was decided, therefore, that a member should have the privilege of inviting one trustee to attend each meeting. The idea of hospital trustees sitting down with superintendents to discuss hospital matters was in itself novel—even radical in the opinion of some. Today the chief difficulty lies in

restricting the size of these gatherings. Once initiated into the import of the hospital realm, the trustee begs for more frequent bids. He just can't get enough of it.

The presence of this particular educational program has manifested itself in numerous ways, but in no instance more conspicuously than in trustee participation at local and state hospital meetings. Hardly one of these administrators who does not have with her on such occasions one or more board members with whom she attends the general sessions and visits the manufacturers' exhibits.

It has been said that the faint-hearted will view this cultivation of the trustee with suspicion and fear. While aware of its benefits, he envisions its grave dangers. In this he is not entirely wrong. The more the board member is encouraged the more he must of necessity be discouraged, or, to put it more accurately, guided.

Two Lessons to Master

One of the first lessons he must learn as part of his educational program is his own precise function—what his duties are. He must be made to realize that his is solely an advisory service applied to general policies, to financial structure and to legislative measures, and is not meant to intrude in any way upon administrative practice. The more apt he becomes in conquering this lesson the better is it for all concerned.

An added responsibility for the superintendent? Of course, it cannot be otherwise. Having stimulated the interest of the lay group, there remains the more difficult task of keeping each individual in line. Particularly embarrassing does this become when there are women on the board, who, because of greater leisure at their disposal, are more inclined to take a hand in "running" things. The only hope of arresting such overdeveloped interest is to check it in its early stages by a perfectly frank reminder that it is the administrator who must manage the hospital.

Having learned what his own duties comprise, the trustee is now ready for Lesson No. 2—the duties of the administrator. Surely there can be no more important part of the educational program than to portray for the lay mind what running a hospital actually means—the great problems in serving satisfactorily those who are physically ill, and coping with their relatives and friends who are mentally disturbed; the difficulties in satisfying the various professional interests, of keeping happy and content a great family of overworked and frequently overwrought workers who day and night are living, sleeping, working and eating under the one roof. Is there any business to which it is comparable?

Greater understanding all around will prove the panacea for many existent ills, and whether he would acknowledge it or not, first advances must come from the hospital administrator. It is he who must initiate the educational process by which the trustee will learn to apply to hospital work his business acumen and professional skill. It is he who must so interpret the hospital in its relation to the public health program that the trustee will regard it in its true light as part of a well-developed community service and study it from this broader angle. It is he who must take the layman by the hand and show him the great joys that are his through participation in a work that offers some interest to everyone.

In proportion as this mutual understanding develops, the administrator himself will benefit by winning greater respect from his board. He will find himself able to speak with greater authority, his influence broadened by the challenge he has accepted. Just as he has deliberately cultivated his board members, so they in turn will cultivate him. His opinion may well be sought in helping select those who are fitted for trusteeship. It may even be his influence that will effect such benefits as definite terms of appointment for board members and presidents, terms that will disbar such service "Til death us do part."

In the meanwhile, however, there are Lessons 1 and 2 to be studied thoughtfully—elementary lessons, to be sure, but upon them rests the future structure of the voluntary hospital. Indications are that the trustee will prove an apt pupil, his progress limited only by the extent of the efforts that surround the educational program—the vision, interest and perseverance, in other words, of the hospital administrator.

Park False Teeth Here!

When within a short period two patients made claims upon the hospital for the loss of false teeth, we realized something had to be done to prevent such property from being thrown out unintentionally by nurses and maids. Our solution was to provide ointment jars (3 inches high, 3½ inches in diameter and costing 9 cents each), one of which was placed in every patient's medicine cabinet or bedside stand. On the outside of the jars was stenciled in letters ¾ inch high "Dental Work Only." This has proved an obvious reminder that artificial dentures should be placed in the special container. In nearly five years since these were installed, no complaints have been registered.—*F. Stanley Howe, director of Orange Memorial Hospital, Orange, N. J.*

A Lawyer Views Anesthetists

The attorney-general of Pennsylvania points out some inconsistencies in the nurse anesthetist's relation to the medical profession, especially the important lack of legal standing

By CHARLES J. MARGIOTTI

WHILE the nurse anesthetist gives excellent service in hospitals, she has no legal standing. This is because the administration of anesthetics concerns the welfare of the patient and may be done lawfully only by a licensed medical man.

It is not enough that a nurse may be competent to administer an anesthetic; if her action is questioned the only consideration is the law.

Under the situation as it exists today, the only way a nurse may be justified in giving an anesthetic is at the instigation of the physician who performs the operation. The surgeon takes all responsibility for actions of all his assistants, including the anesthetists, even though the anesthetist also may be a licensed physician.

There is no valid reason why the anesthetist should not be a registered nurse, provided, of course, that she has the proper training and qualifications. Nevertheless, objections to the nurse anesthetist come from doctors and dental anesthetists who contend that the nurse encroaches upon the field of medicine. If the nurse anesthetist is qualified to do the work efficiently, doctors should be willing to accept her, and she should receive commensurate remuneration.

Nurse anesthetist service has a number of distinct advantages which the doctor should not overlook. The educated nurse is an intelligent observer of the mental and physical phenomena of disease. She understands the reaction of the patient to various drugs and to the treatment the doctor prescribes to relieve symptoms. She has a knowledge of exacting nursing procedures that contribute to the patient's recovery.

A nurse's education, teaching as it does gentleness, tact and expert care in the relief of the sick, as well as affording continued critical observation of the patient, is a splendid background for post-graduate work in anesthesia.

Most important is the assurance of a continuous anesthesia service in hospitals through nurse anesthetists. Increasing perfection of technique assures skillful anesthesia care to all patients at all times. It seems far preferable to the practice of having anesthetics administered by interns or by special medical anesthetists who may not always be available.

Despite all these things, the medical man remains in complete control of the situation. Unless he gives the word, the nurse anesthetist may not function. Now she has every desire to cooperate fully with the medical man. She prefers to be under his complete jurisdiction. She feels that she has a distinct contribution to make to the whole science of medicine and that she is capable of doing it well.

Urges Legal Recognition

Doctors and nurse anesthetists should throw aside any differences they may have and cooperate on mutual ground for the advancement of the whole field of medical science. The nurse anesthetist should be legally recognized as a highly specialized branch of the medical profession. The work of the nurse anesthetist should be standardized. Proper courses of training should be set up by the medical profession. Progress should be carefully noted, and when the medical profession is convinced that the nurse anesthetist has attained the required efficiency to hold the lives of patients in her hands, then she should be accepted as a trusted helper.

Because of the importance of the anesthetist legislation should be enacted by the states to recognize her under law. An applicant for a nurse anesthetist's license should be required by the state to pass a strict examination that will demonstrate her qualifications without question. Once the nurse anesthetist is licensed, the state should maintain proper supervision.*

*From a paper presented before the American Hospital Association convention, September, 1937.

Built for Quiet and Comfort

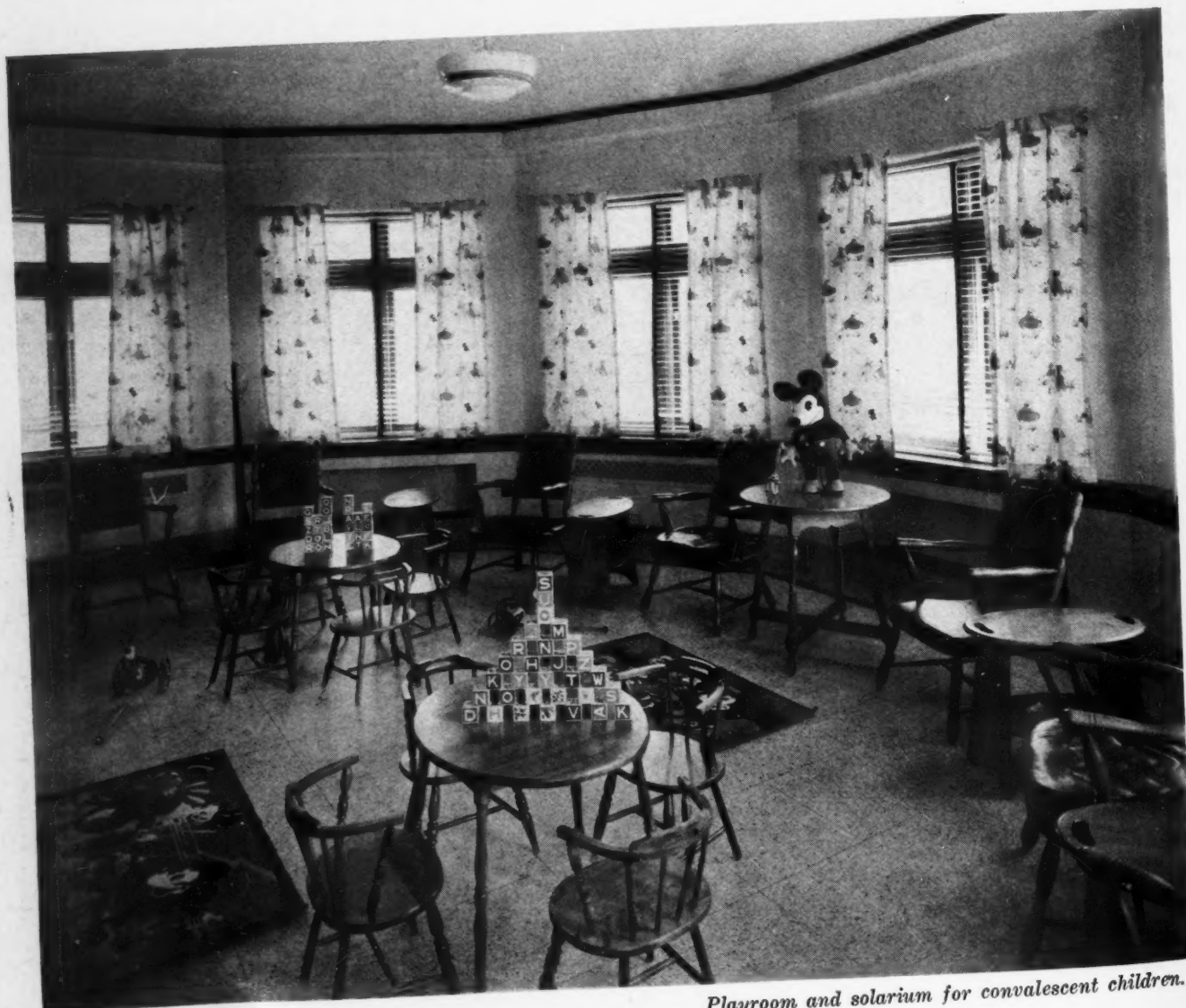
By WILLIAM SCHULZKE and MARGUERITE N. BROOKS

THE Moline Public Hospital is located on a high point in the city of Moline, Ill., where there is an interesting view of the Mississippi River valley. It is easily reached from the industrial, business and residential sections. This hospital serves not only the city of Moline, but also the cities of East Moline, Rock Island and Silvis, as well as the territory within a radius of twenty-five miles.

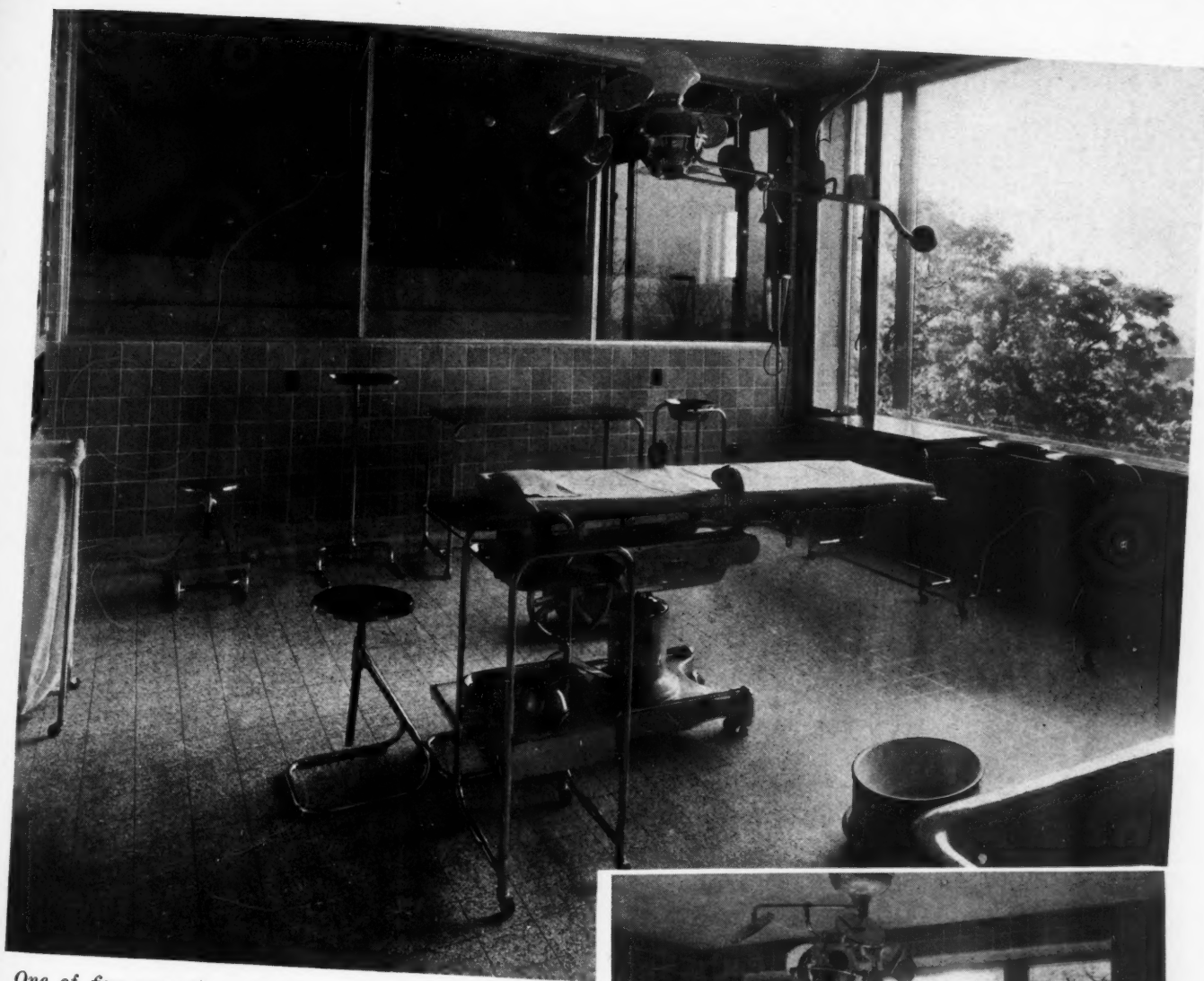
A municipally operated institution, the Moline Public Hospital was first built as a three-story building in 1896. A fourth story was added in

1906. In 1928 a new wing, 36 by 92 feet, was added. In 1933 the original building was completely remodeled under a Civil Works Administration program. In 1935, with the building taxed to capacity, an application was filed with the Public Works Administration for a grant of \$103,909 toward erecting a \$260,000 addition. This building was completed May 8, 1937.

The illustrations accompanying this article show the arrangement of a typical patient floor and present the first unit of a future U-shaped building, following the lines of the present building.



Playroom and solarium for convalescent children.



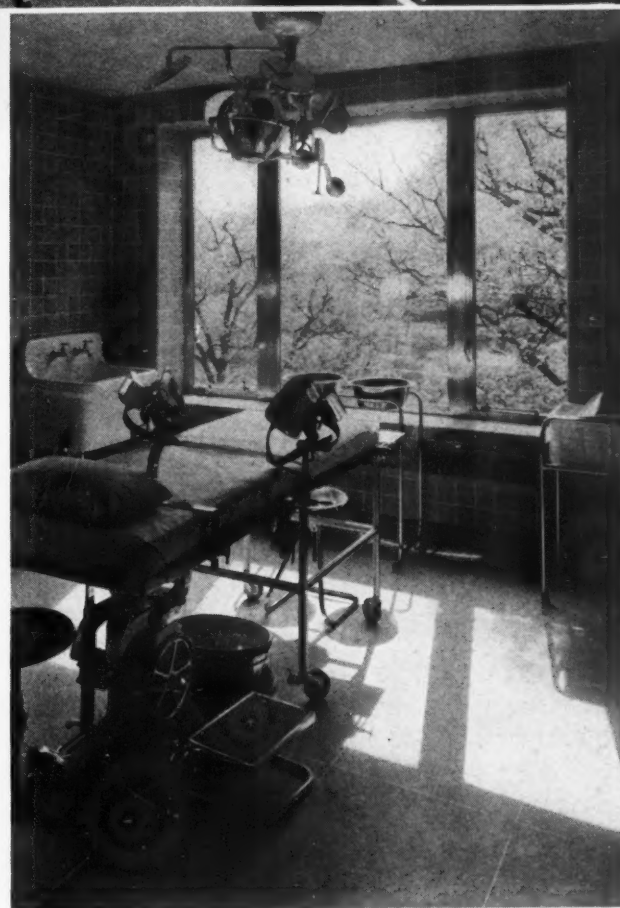
One of five operating rooms.

The building is oriented on the property so that all patients' rooms have the desirable east, south and west exposures.

The exterior is a straightforward expression of the plan and indicates the important activities of the institution. The basement windows are well above grade, and clear exposures are provided on all elevations. The walls are faced with a light buff brick, trimmed with Indiana limestone.

The basement contains the main kitchen, diet laboratory, dietitian's office, staff dining room, general dining room, refrigerators, locker rooms, central linen room, store and supply rooms and the air conditioning equipment room. The hospital laundry is connected by a tunnel to the main building and a second connection is made through the ironing room directly adjacent to the rear of the kitchen and the laundry building.

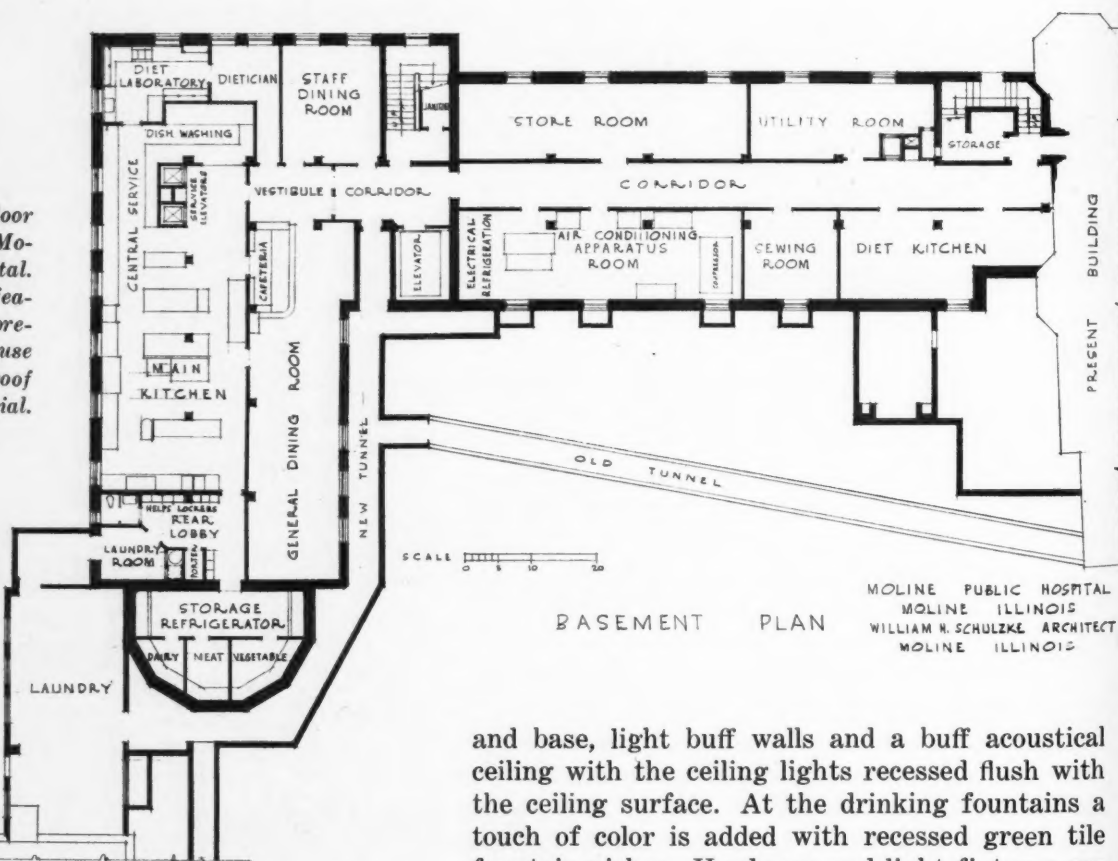
The first floor is planned with the entrance lobby, ambulance entrance, reception rooms and the administrative section in the center of the main wing. The entrance lobby walls are of a mottled buff terra cotta, and the terrazzo floor has a central design typifying hospital service,



One of the delivery rooms, flooded with sunlight.



Plans of first floor and basement, Moline Public Hospital. An outstanding feature is the quiet preserved with the use of modern fireproof acoustical material.

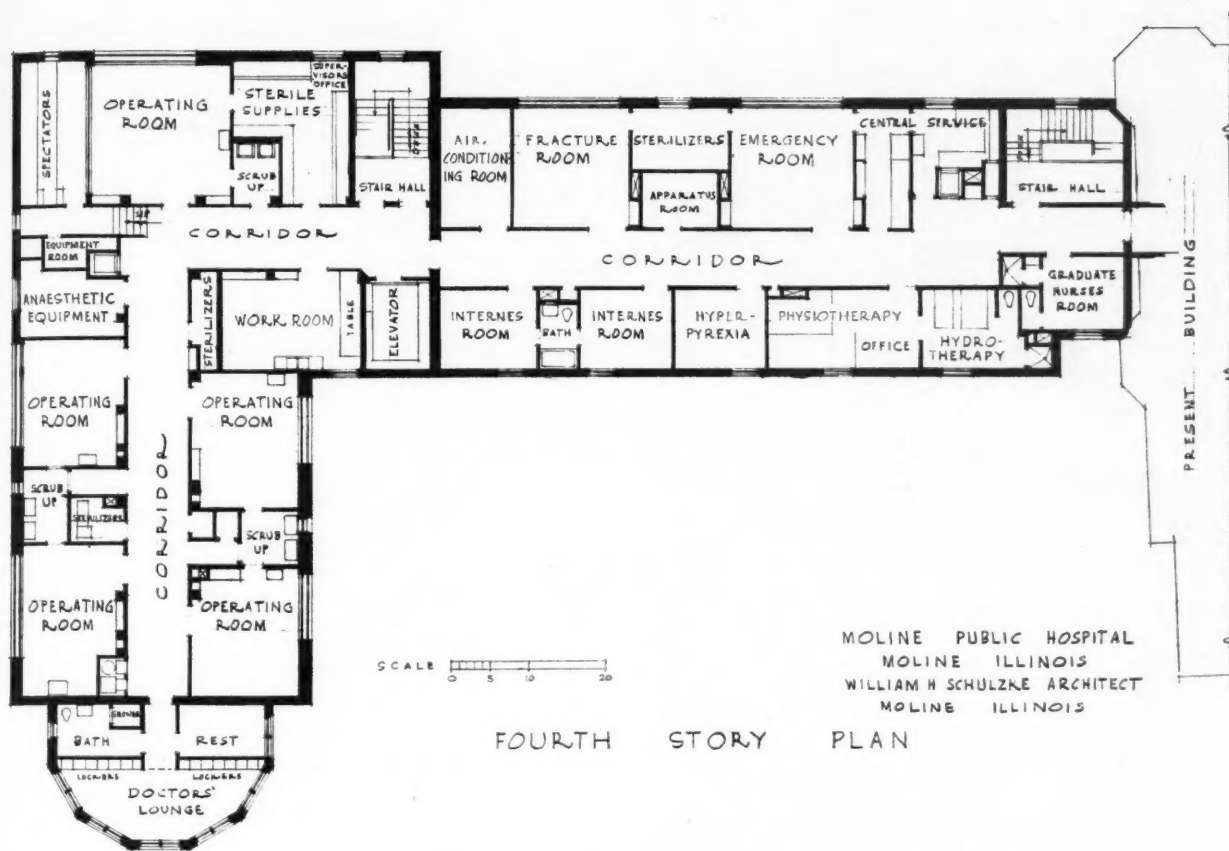


which is explained by a tablet on the wall informing the visitor that

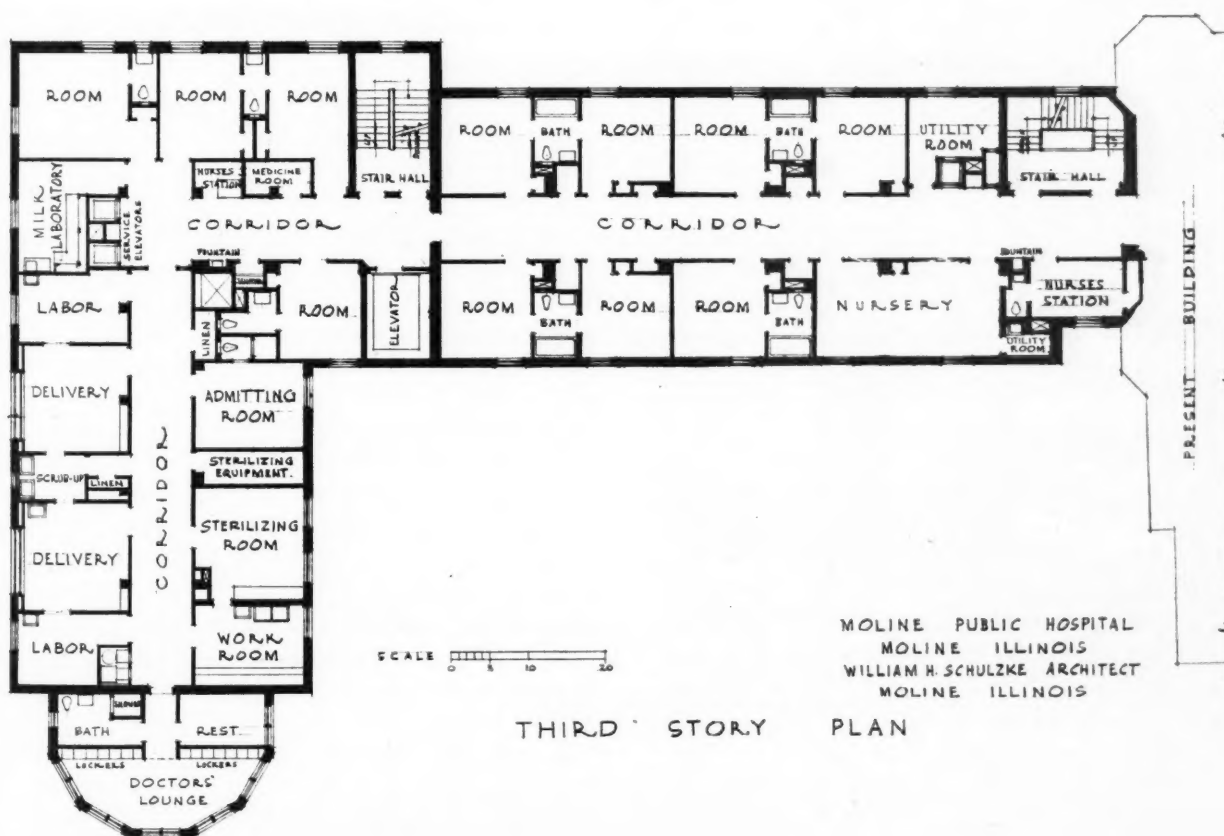
Twenty-four hours each day,
Twelve months of the year
Constant traffic through this lobby
Bears witness that the circle of
Human Kindness still cares for the sick.
In the corridors the field of the floor is of a
marbleized brown mastic tile with terrazzo border

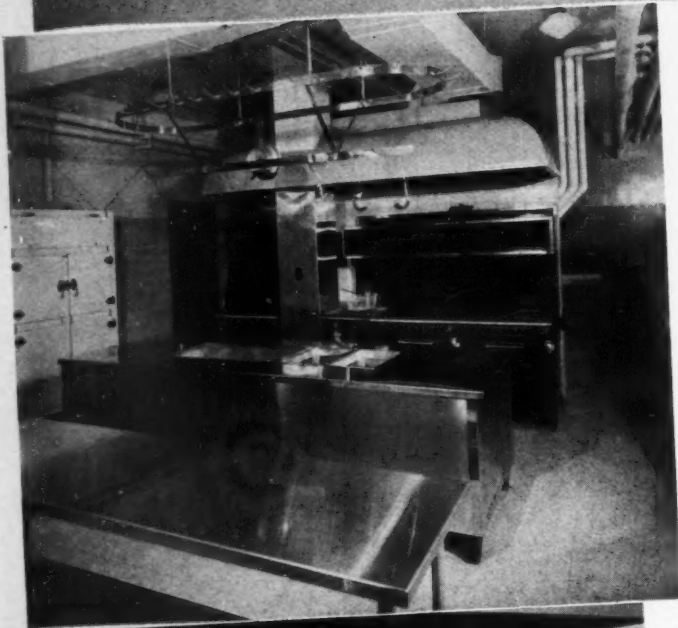
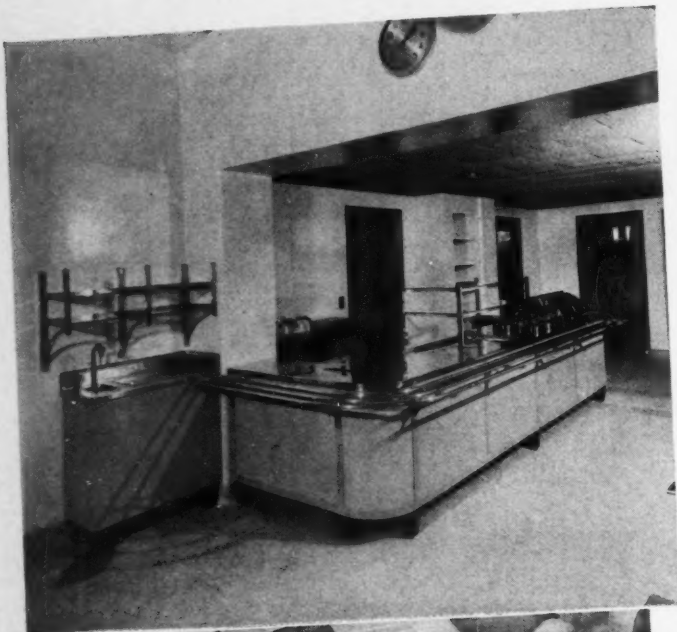
and base, light buff walls and a buff acoustical ceiling with the ceiling lights recessed flush with the ceiling surface. At the drinking fountains a touch of color is added with recessed green tile fountain niches. Hardware and light fixtures are a satin finish chromium.

An outstanding feature of the new hospital unit is the quiet preserved, with the use of modern fireproof material. All of the corridor ceilings have acoustical tile, while the solid slab doors strike against heavy felt strips recessed into the metal frames and jambs. This unusual feature has made it possible to eliminate door noises. The



Plans of the third and fourth floors of the new Moline Public Hospital wing. The second floor — the plan of which is not shown — is comprised of private rooms. This floor also has a large solarium. The third floor, as can be seen, is the maternity section, and the fourth, the operating suites and physical therapy department.





Views of the nurses' dining room, with cafeteria counter, and of the main kitchen.

simple lines of the slab doors with metal jambs bring out the beauty of the grain of the wood and continue the color treatment.

The new wing of the hospital contains the pediatric department, isolated from the main building by soundproof corridors and doors. A large solarium playroom at the south provides ample sunshine for convalescent children. The pediatric department is hand decorated with juvenile designs in pastel oil colors.

The second floor is comprised of private rooms and has been divided into single rooms, single rooms with toilet, single rooms with bath and suites with bath. This floor has a large solarium. Every provision has been made for the patients' comfort. Draperies and furnishings are highly individualized and have been especially selected to blend with color schemes of the rooms. Every effort has been made to avoid institutionalized appearance without sacrificing utility and efficiency.

The third floor is allotted to the maternity section. The obstetrical department is located in the wing off the main corridor and is isolated with sound-absorbing materials and noiseless doors. This department is complete in itself and examination of the drawings will reveal the carefully arranged rooms with special attention given to time-saving operations. The nursery, sound-proofed and isolated, is conveniently located in the main building.

Convenience and Safety Assured

The fourth floor contains the five operating rooms, complete with doctors' scrub-up, sterilizing and work rooms. One room is equipped with an amphytheater completely isolated by plate glass and equipped with crystal microphones for intercommunication. Both the third and fourth floors have space allotted for a doctors' lounge, rest room and shower. The walls are covered with a light gray-green matt finish tile and the doors and cabinets are enameled to match. Floors are of terrazzo, divided into small squares by a welded network of brass strips grounded to the water pipes of the building. Switches and wall receptacles are of the sparkless, explosionproof type. Radiograph receptacles in each operating room provide view boxes for x-ray films. The addition of the new operating rooms provides space in the main building for a central service room, emergency room and a fracture room completely equipped with x-ray. Across the corridor is the physical therapy section, with its equipment for hyperpyrexia, physiotherapy and hydrotherapy.

The elevator extends to the present roof ready for future extension to the fifth floor, which will

contain patients' rooms. Plans for this addition have been made and construction is contemplated for the near future.

Structural methods and materials possessing sound-absorbent properties have been employed in the construction of the building. The floor, wall and ceiling finishes of similar quality have been used, and the hardware and equipment selected are as nearly noiseless in operation as possible.

All door frames have been provided with shock and sound-absorbing strips, presenting a continuous felt surface to the door on closing. These strips are adjustable for wear at the top and sides of the doors. Friction hinges prevent slamming and make possible the holding of the door at any point.

Door Action Is Modern

The door is opened from the outside by simple pressure and pulled open from the inside by an arm hook of the hospital type. Doors so equipped cannot be slammed by drafts and can be opened by attendants carrying a tray or other articles. The doors are equipped with dead locks operated by a key for locking the rooms when not in use.

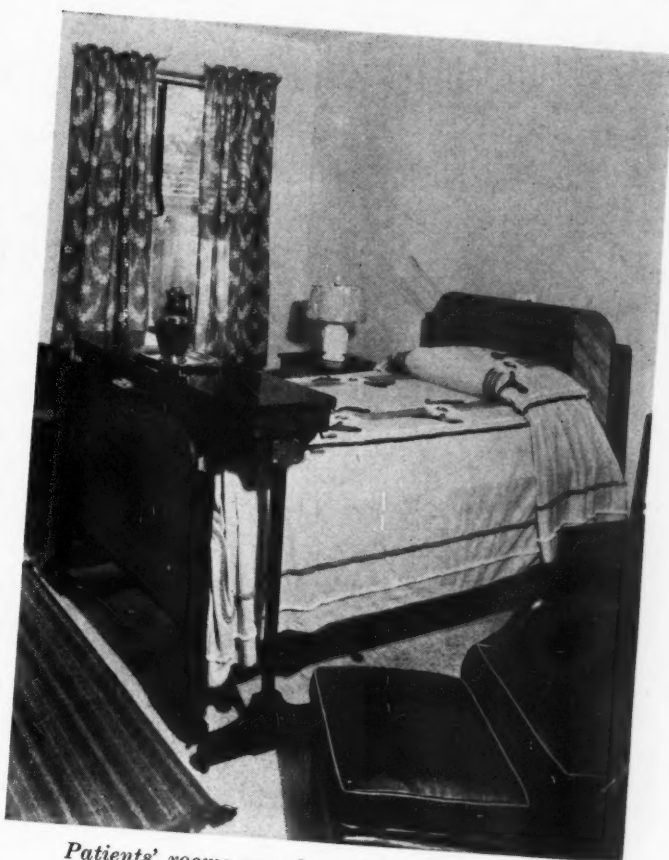
A forty-code doctors' call system with chime signal units distributed throughout the hospital is electrically operated at the switchboard. Aerial and ground radio outlets are installed in all patients' rooms.

Control of temperature throughout the building to meet hourly changes caused by variations in the sun's heat is a feature of the air conditioning system.

This zone control assures an adequate supply of cooled air in hot weather on the side of the building catching the brunt of the sun's load at any particular time. By equalizing the effect of the sun's heat throughout the various rooms, a uniform temperature will be maintained at all times. This system will condition the first four floors of the hospital, covering 12,800 square feet. This includes an eighteen-bed pediatric department, five operating rooms, storage for anesthetics, sterilizing rooms, an admitting room, two labor rooms, two delivery rooms, two solariums and twenty-two single rooms.

The surgical and obstetrical departments will receive a 100 per cent fresh supply of washed and filtered outside air, making a complete change every 20 minutes. Winter humidification is supplied to control the relative humidity. The installing company's engineers found that with air conditioning it was possible to maintain a predetermined relative humidity in the operating rooms sufficiently high to minimize the generation of static electricity.

It has been suggested that the most desirable



Patients' rooms are cheery and comfortable.

condition to maintain in the operating rooms is a temperature of 80° F. with a 55 per cent relative humidity. It is believed that this relative humidity is high enough for complete safety from explosive anesthetics.

Heating and Ventilating Devices

The air conditioning system includes two units with by-pass sections, water coils, filters and sprays for humidification. Heating coils are placed in the supply ducts for zone control. Other features include sound absorbers installed in the supply ducts. Other equipment consists of compressors, ice-making machines, an exhaust fan to blow out all air supplied to operating rooms and supply outlets.

The use of the by-pass in air conditioning has been found of great benefit because it provides simultaneous and independent control of both temperature and humidity. According to this method, a portion of the returned air from the conditioned space enters the apparatus immediately in front of the fan where it diffuses with the newly conditioned air. While an appreciable part of the benefit is the economy in refrigeration required for spray water, owing to the small percentage of total air taken through the spray, much greater benefits are the sensitivity and range of control possible with such an arrangement.

With the Roving Reporter

At Your Service

• It is not sufficient always that the hospital have ample equipment for its own use; it must be prepared to answer outside calls when emergency arises. Those who went a-journeying with us in September to Atlantic City, N. J., and spent some time browsing about the Atlantic City Hospital will recall the services that institution is rendering in sending out oxygen tents and similar equipment to suffering visitors in the famous resort hotels. It is a long jump indeed from Atlantic City to Berkeley, Calif., but distance means little to those who follow the travels of the Roving Reporter.

In the Berkeley General Hospital, it seems, is a regular sickroom supply rental service. It is based on the assumption that patients who are sick or convalescing at home will probably find it more feasible to rent hospital and bedside equipment needed for a short time than to purchase such items. All they have to do, therefore, is to call the hospital and explain their needs to John W. Harkness. Included in the equipment now available are hospital beds, fracture beds, crank beds, folding bed cradles, commodes, bed sides, Balkan frames, Bradford frames, back rests, bedside tables, wheel chairs, invalid walkers, crutches and canes, splints and miscellaneous bedside equipment.

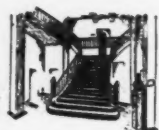
In fact, a special splint rental service is being developed. Right now the hospital has ready for call Bohler clavicle splints, Jones hip splints, both metal and wood, Thomas arm and leg splints and sundry aluminum splints and traction apparatus. What is more, splints and equipment not in stock will be added in response to specific demands as the need arises.

For Memory's Sake

• When visiting Brooklyn recently we made a point of finding out about those folded pieces of paper that patients leaving the Methodist Episcopal Hospital frequently carry away with them. They can't be receipted bills because they were in the patients' possession before they stepped up to the desk.

You will never guess, so we will tell you—they're menus, selective menus bearing at the top an attractive little sketch of the main stairway of the

hospital. The patient questioned confessed frankly that he was taking it home as a souvenir. "I want my friends to see what good food they gave me while I was in the hospital."



METHODIST EPISCOPAL HOSPITAL
BROOKLYN, N. Y.

Name _____

Room No. _____

Date July 8, 1937

DINNER

(Check Choice)

Choice
Soup
Tomato juice

Choice
Broiler
Lamb chop

Choice
Parsley potato
Baked potato

Choice
Squash
Peas
Buttered beets

Choice of bread
White Rye
Cracked wheat

Choice
Maple walnut ice
cream
Gingerbread, lemon
sauce
Honeydew melon

Tea — Milk
Special Orders

An extra charge will be made for
food not on the menu.

NURSE IN CHARGE



METHODIST EPISCOPAL HOSPITAL
BROOKLYN, N. Y.

Name _____

Room No. _____

Date July 8, 1937

SUPPER

(Check Choice)

Choice
Stuffed tomato
salad, potato
chips

Egg, tomato,
potato salad —
Poached egg on
holland rusk,
lettuce — dress-
ing

Choice of bread
White Rye
Cracked wheat

Choice
Cinnamon buns
Raspberry short-
cake
Preserved peaches
Junket

Tea — Cocoa — Milk
Special Orders

An extra charge will be made for
food not on the menu.

NURSE IN CHARGE

This in itself merited investigation, so back we go to the office of Grace B. Hinckley, superintendent, to discuss the "whys" and the "wherefores." Instead of presenting the patient with a white slip containing a list of various dishes each day, from which he might select his breakfast, dinner and supper, it was decided to give him a printed menu that had some appeal—one that he would like to show his relatives and friends. A young nurse possessed with artistic ability and talent for drawing made a sketch of the stairway for the menus in the general hospital, also one of the front door to the maternity building for patients' menus in that unit.

The results are shown in the accompanying illustration, which shows only dinner and supper menus. Pa-

tients are enthusiastic, according to both Miss Hinckley and Marian Randall, dietitian. "They are constantly asking for copies to take home as souvenirs," Miss Hinckley said.

To Read Is to Believe

• A visit to Montefiore Hospital, New York City, is always good for one or more thrills. Recently we encountered six of them in the form of six perfectly good copies of *The MODERN HOSPITAL* that are received each month and put to certain specific uses. And the intelligent use of hospital publications irrespective of their name or origin is something to write about.

It is interesting to see what happens to them at Montefiore. One copy is addressed to the hospital and is bound for permanent reference in its exceptional medical library; another goes to the dietitian; a third to the superintendent of nurses, and a fourth to the president of the board of trustees (other hospital administrators, please take note). Dr. E. M. Bluestone, the director, receives two personal copies, one set of which is bound every six months and forwarded to the library of the Hebrew University in Jerusalem to be used especially by the school of nursing of the Hadassah medical organization of which he is a former director. He has been sending these since 1922.

Now let's see what becomes of Doctor Bluestone's other personal copy. After studying it carefully (he calls it his "MODERN HOSPITAL Hour") articles are clipped and sent to various people in the hospital. Articles pertaining to new construction and to plant equipment go to the chairman of the building committee of the board of trustees and then may be referred to the engineer also. Articles on group hospitalization are sent to the member of the board who has been delegated to keep the board abreast of the subject. Personnel relations, medical staff and nursing are similarly handled.

Many of these articles are also routed to the heads of the respective departments in the hospital even though some of them receive their own personal copies of the magazine.

"While some of our trustees receive copies of *The MODERN HOSPITAL*," says Doctor Bluestone, "most of them do not, and this method of informing our trustees is one way of keeping them *au courant* with hospital progress. Besides, the clipping draws their attention more sharply to articles which should be emphasized . . . Clippings are sometimes sent with marginal comments for their attention."

Goods Well Bought

By MAY A. MIDDLETON

AN AMERICAN financier says that experience has taught him that the problem of spending money judiciously and to good purpose is a more difficult task than the acquisition of money.

The steady advance in the art of buying has been one of the determining factors in the development of scientific salesmanship. Personal contact between buyer and seller is no longer vitally important; salesmanship is on a more impersonal basis.

Someone has declared that knowing intuitively when and how to purchase with an element of good luck is the characteristic of a good buyer; it is also the characteristic of a gambler. Today, the successful buyer must be posted on the particular requirements of his hospital. His records show the quantities consumed. The laboratory will furnish analyses and physical tests. Market reports show the available supply. With this information the purchasing agent can obtain the lowest price, the best quality, satisfactory terms and prompt delivery.

Cost Does Not Determine Quality

Price alone is not the determining factor in making a purchase. High cost is not necessarily an indication of quality; it may be caused by lack of demand. The prime essential is to purchase at the lowest possible price that which answers most fully your needs.

Common sense is an excellent attribute. It is foolish to make exhaustive experiments when the annual purchase is less than the cost of the experiments.

If needs for one class of materials are large, the buyer distributes his orders with two or more reliable firms. In these days of labor trouble it is wise not to have all one's eggs in one basket.

The buyer of a hospital situated in a small town is often forced to purchase from local firms. An accurate account of the purchases should be kept. He then can ask for quotations on a year's supply

Maximum buying efficiency has not been reached unless the price paid is the lowest obtainable for the quality bought and unless some good purpose has been served the hospital by the consummation of the transaction

of staple goods from the large firms throughout the country. With these figures before him the local jobber will realize the value of the hospital business and be eager to serve it with profit both to the hospital and himself.

Salesmen must be made sure that they will receive a square deal. If a salesman is tricked into accepting an order by which his firm loses money he naturally will attempt to evade the terms of the contract.

Competition is the soul of trade. Quotations are for the buyer alone. To disclose these prices to a competitor is sharp practice. It may give a temporary advantage but the lowering of the standards of the buyer by such a practice soon injures the hospital's purchasing power.

It is foolish to use the offer system when getting quotations. Such tactics soon become known and the original quotation is made correspondingly high.

Information Needed by Buyer

The purchasing agent should have information on the following factors:

1. Supply — available sources from which articles or goods may be obtained and the probable quantities that will be produced.
2. Consumption — quantities purchased in the past.
3. Quality — detailed specifications.
4. Prices — past prices and present quotations.

If the buyer has this information he knows exactly where he can obtain what he needs, the quantities he requires, the quality he must have and the price he should pay.

The buyer should know as thoroughly as possible the character and the particular uses of the

articles he handles and their importance to the hospital. He must consult freely with the heads of departments, explaining the necessity of clear specifications, and gain their cooperation in keeping a minimum supply on hand.

The purchasing department buys, receives and inspects, secures low freight rates, maintains merchandise in storeroom at minimum and has deliveries made in accordance with needs. It guards goods from pilfering and deterioration, makes proper stores accounts, checks invoices and obtains information on markets.

While the foregoing work may be done by one person in a small hospital, most hospitals need a well organized department. There should be no man in the organization whose presence is indispensable.

Whatever the size of the department a proper system by which the work is performed is essential. Simplicity must be the keynote of the system. The necessary data must be concise, readily understood and easily accessible. Justification of a system is its effectiveness in covering with accuracy and dispatch all points in the work of the department. Too many forms are cumbersome and retard work.

The department should have a good library of catalogues properly indexed. Records of sources of supplies constantly must be kept up to date. Much valuable information can be obtained from *The HOSPITAL YEARBOOK*.

Card System of Past Purchases

A card system of past purchases is necessary for a well-run department. These cards need not necessarily cover all the 600 or more items purchased; 150 or 200 active items will supply the necessary knowledge to the buyer of the average hospital. These cards should contain the name of the manufacturer, the price, the amount bought and the date. They are indexed under the article purchased.

Requisitions from all departments properly signed should be sent regularly each week to the department. Requisitions are the bases for all purchases.

Requests for valuable instruments should have the approval of all the doctors using them. This is most important. A thorough discussion of the use and cost before the purchase is made will save money and prevent the buying of instruments used for a few times and then discarded as unsatisfactory.

The storing of goods by a well-meaning supervisor soon destroys the economical running of the purchasing department. A thorough understanding of the budget allowance together with friendly

cooperation of departments will save the hospital hundreds of dollars.

Better prices are obtained when a month's supply of nonperishable goods is purchased. If a contract can be obtained whereby the hospital is protected against a falling and rising market, larger orders can be placed with profit.

Future orders covering a season's supply must be carefully studied. Unstable labor conditions and government regulated production make the future uncertain.

If the buying of the hospital is centralized the greatest economy can be effected. The superintendent should be constantly and closely in touch with the buyer.

Avoiding Mistakes in Orders

Orders given to firms should be explicit. The purchaser should state concisely and clearly the amount, description, price to be paid and date of delivery. Triplicate copies in different colors are the usual forms; the original goes to the firm, one copy to the storekeeper and the third copy to the bookkeeper. In hospitals there will always be emergency orders given by telephone. To avoid mistakes or confusion these should immediately be confirmed on the regular written forms. Many errors are avoided if the purchasing agent demands that the number of the order be entered on the invoice.

Firms should be instructed not to fill orders unless they have a properly signed requisition with the hospital number.

Much money is lost unless firms are compelled to live up to the terms stated clearly on the orders and unless the invoices are carefully checked to see that the directions given are explicitly carried out.

The invoice is sent to the purchasing agent who (1) attaches the receipt; (2) compares the invoice with the order; (3) checks it with the material received; (4) verifies prices, terms and freight allowance; (5) attaches the number of the department to be charged; (6) proves extensions, and (7) stamps the invoice with date and signature and sends it to the accounting department.

Tact consists of doing the right thing at the right time. Tact, a constantly growing technical knowledge and common sense are requisites which, blended with energy, directness, honesty and an ability for hard work, make an ideal head of a purchasing department.

"Goods well bought are half sold," was the old maxim. The best has not been done, the maximum efficiency has not been reached unless the price paid is the lowest obtainable for the quality bought and some good purpose has been served the hospital by the consummation of the transaction.

In group hospitalization plans

Where Publicity Begins

By PERRY ADDLEMAN

PUBLIC relations problems in connection with insurance plans for hospital care must start with questions of policy rather than publicity. Means of obtaining publicity are manifold if the plans and operations are fundamentally serviceable to the community, and if they are carried out in such a way that they become good subject material for publicity.

No person or hospital should take an attitude for or against group hospitalization. On the contrary, it should be thoroughly investigated by completely open minds to determine what it can or cannot do for a particular city or community. Here is a place where publicity should be used immediately. As the basic data are gathered, processed and studied to determine their significance and meaning in a local situation, they should be publicized so that the whole community may be brought in on the study and thereby may pass intelligently on the idea of group hospitalization when at a later date it is made a kind of community referendum.

This procedure is important because whenever it has been followed consistently in starting a group hospitalization plan, the plan has received widespread community support in matters both of working fund and membership enrollment.

One-Hospital Plans Are Weak

A question that immediately arises in studying plans for hospital care, particularly in middle-sized and smaller cities, is whether a sound plan can be developed for a single hospital when other approved general hospitals exist in the community. A plan, to be rational and sound, should include at least a majority of all approved general hospitals in the area which the plan proposes to serve.

Let us define one-hospital plans and any plans that do not include a majority of approved hospitals in a given area as minority plans. Let us refer to plans that embrace a majority of approved hospitals in a given area as majority plans.

Minority plans are inherently weak in many regards. Clearly, they do not give subscribers a free choice of hospital. Under the circumstances, they cannot claim that they allow an unrestricted choice of physician.

If minority plans are approved without qualification, there is danger that minority group hospitalization schemes may be used by single hospitals as an unfair and perhaps unethical bid for public patronage which would discriminate against other hospitals in the community.

There is always a question whether minority plans are not to some extent flying under false colors as far as the public is concerned. Is group hospitalization primarily a scheme to fill hospitals and to pay them for the service they render? When it is conceived as that, its prime responsibility is to its member hospitals. Or is it a purchasing service primarily responsible to its subscribers and in effect nothing more than a consumer cooperative? There is little doubt that either position is unsound and ultimately untenable.

Must Be Conceived as Public Utility

The consumer cooperative concept might eventually lower the present standards of hospital care by forcing hospitals to cater to popular and short-sighted demands of the subscribers to a plan. Conversely, in a group hospitalization plan completely controlled by member hospitals and operating primarily for their benefit, there is grave danger that the plan may become unresponsive to even well-defined public needs and that it may place responsibility to its member hospitals above responsibility to the public.

It becomes plain, then, that a sound plan for hospital care must be conceived, organized and operated as a public utility. It must maintain an objective and independent position in which its responsibilities to member hospitals which provide the service are balanced with its responsibilities to subscribers who need hospital care. A minority plan or a one-hospital plan, especially, would find it hard to maintain at all times such objectivity of view and such balance in operation.

This need of balanced responsibility injects other questions relating to corporate structure, corporate control and possible sources of working

funds for group hospitalization plans. It is proposed, first, that plans for hospital care have corporate entities separate and distinct from member hospitals. Entirely aside from considerations of responsibility and control, separate corporate structure provides the only framework in which clear-cut accounting of costs, use of service, and surpluses or losses may be done.

Second, control of the corporation should be in the hands of men who honestly represent all three groups whose interests come to focus in the hospital—the hospital management, the medical profession and the consuming public. No one of these groups should obtain a preponderance of control.

Third, there is doubt whether even subscriptions to the working fund for a plan should be accepted from member hospitals. Hospitals should not be allowed either to advance lines of credit or underwrite the liabilities of a plan, because these acts amount in fact to subscriptions to working capital. They clearly give to those who make such subscriptions a moral right to exert a control that might in turn dull the sense of balanced responsibility to public and to member hospitals.

I do not believe subscriptions to the working fund of a plan should be made by charitable agencies. This is an expression of personal opinion. But if group hospitalization has anything to offer to our present day social philosophies, it is that in the whole field of social services, all those who are normally employed may increasingly be given means and taught how to stand on their own feet and pay their own way. Obviously, any connotation of charity or of charitable subsidy invalidates this whole thought.

Not a Class Proposition

There has been a tendency from the very start to look upon group hospitalization as a proposition applicable only to certain economic classes. This is a narrow and unimaginative point of view. If sufficient flexibility in schedules of service is put into plans, and if costs and rates are gauged accurately, there is no more reason why group hospitalization should be a class proposition than that life insurance should be a class proposition.

Last and most important, there arises the question of whether plans for hospital care should be incorporated with not-for-profit charters, or incorporated as commercial and proprietary businesses. There appears to be no reason why a commercial insurance company cannot appropriately and safely write policies that provide a cash indemnity to policyholders to be used toward payment for hospital care. There is no reason of ethical nature why such cash allowances could not be made for payment of medical services.

These policies are "dollars contracts." They are not "service contracts." They do not require that companies writing them have service contracts with, for instance, hospitals providing care to policyholders.

Group hospitalization must do more than provide a stipulated number of dollars to policyholders; rather, it must provide stipulated units of service and care in cases of need. Consequently, hospital service corporations must have service contracts with at least the majority of hospitals in a given area.

Commercial Set-Up Undesirable

Since the majority of the general hospitals in America are nonprofit corporations, they cannot consistently make comprehensive service contracts with commercial stock and dividend-paying organizations. It is entirely conceivable that such firms might eventually dominate the whole development of hospitals contracting with them. In any event, these firms might easily make substantial profits, while the nonprofit hospitals furnishing the service to policyholders were appealing to the public to make up deficits incurred in providing service to policyholders.

Thus, we see that, the organization of our general hospitals in America being what it is, it is as undesirable to provide this social service through dividend-paying commercial organizations as it is to provide it through tax subsidy and so-called governmental socialization of hospital care.

For many years certain health services have not been clearly defined as either hospital care or medical care. There continue to be controversies in the medical profession, in hospital organizations, and between organized medicine and hospital associations concerning these borderline services. In most instances, the controversies have been gentlemanly and dignified and have seldom manifested any purely selfish bias.

Plans for hospital care must maintain a rigidly logical and unbiased position. They cannot be used as instruments of pressure or coercion, either by hospitals upon the medical profession or by the medical profession upon hospitals. Group hospitalization plans should be readily altered to accord with what constitutes good and usual practice in approved hospitals and among members of the medical profession in good standing.

Public relations problems and publicity problems are basically solved when by rigorous analytical methods and constructive speculation about our services equations are established that are sound and equitable to all persons and groups concerned.*

*From a paper presented before the convention of the American Hospital Association, Sept. 14, 1937.

HOUSES and GARDENS

for Interns

for Patients

THESE cottages and gardens are not on a country estate. Portland Sanitarium and Hospital, Portland, Ore., provides these attractive houses for its married interns. Each cottage has a living room, 13 by 19 feet, a bedroom, dinette, kitchen, bathroom, laundry equipment and an electric range and refrigerator.

The garden shown is in the hospital courtyard, secluded from passers-by. The hospital is so arranged throughout that all patients have free access to the garden. Beds are equipped with large ball-bearing wheels and all rooms and elevators have wide doors to permit easy egress into the sunny garden.



Two Publicity Prizewinners

THE middle of May is a busy time in a rural community, and Midwestern ruralists observe rather strictly the Sunday "blue laws" handed down to them from their New England forefathers.

Since Parkview Hospital serves the small northern Indiana city of Plymouth and the surrounding rural community, the Sunday following May 12 was chosen for that institution's observance of National Hospital Day.

This thirty-bed institution was awarded first prize for its National Hospital Day publicity, in the small hospital classification at the convention of the American Hospital Association in Atlantic City, N. J.

The remarkable thing about Parkview's publicity program was that no money was spent. Funds necessarily are limited in this voluntary institution and no sum had been allotted for this purpose.

Hospital Day never had been observed at Parkview, and the innovation brought the county's residents to the institution for their first real

Less Than 100-Bed Class

"look in" behind the scenes. To further curiosity about the technical equipment of the hospital, the local papers carried photographs of the laboratories, operating room, emergency room and x-ray room and equipment.

The city of Plymouth has two daily newspapers in addition to a number of weeklies in the area which the hospital serves. Weekly papers carried invitations before observance of the day, and the local dailies carried articles the entire preceding week.

All ministers in the county were contacted and asked to make announcements of the program at the Sunday services. The Plymouth Business and Professional Women's Club and a boys' health class from a near-by town made an extensive inspection of the hospital prior to National Hospital Day, which served to disseminate information regarding the institution and to arouse the layman's curiosity about its equipment. Announcements also were made of the event at all local organization meetings, including civic clubs, charitable societies and professional and business clubs.

A human interest, as well as personal touch was given to the program by the contest for babies

(Continued on page 66)



What a play the local newspapers in Plymouth, Ind., gave to the town's very first Hospital Day celebration!



Tell How They Did It

More Than 100-Bed Class

IT WAS a perfect New England day with the temperature between 78° and 80° F. The desk clerk at the New England Sanitarium and Hospital looked up from his work. It was shortly after noon, May 12, 1937.

"Here they come," he announced to Chairman Paul R. Cone of the Hospital Day program, and they kept coming—2,500 people in all—up until 5:30 p.m., in spite of the fact that the hospital had advertised its program between the hours of 2 and 5 p.m.

The 135-bed institution, which won first place in the 1937 National Hospital Day publicity contest for larger hospitals, is located in the beautiful Middlesex Falls state reservation about ten miles from Boston, and near Stoneham, Mass. The main buildings overlook a large lake, "Spot Pond." Between the buildings and the road, which skirts the lake, are spacious rolling lawns and scattered trees. Flowers had been set out and the lawn was in the best of condition for the event.

Guests arrived from all over New England, since the New England Sanitarium and Hospital gives both hospital and sanitarium service. Young men on the parking ground directed them to the white and green information booth and the main lobby. Here the visitors were

greeted, received programs and were started on tours of the hospital.

Nurses were placed at strategic points throughout the hospital to direct the visitors. Since experience had taught the committee that sometimes visitors get lost or want to lag behind on conducted tours, each guest was permitted to wander through the hospital following numbered signs pointing to the different departments.

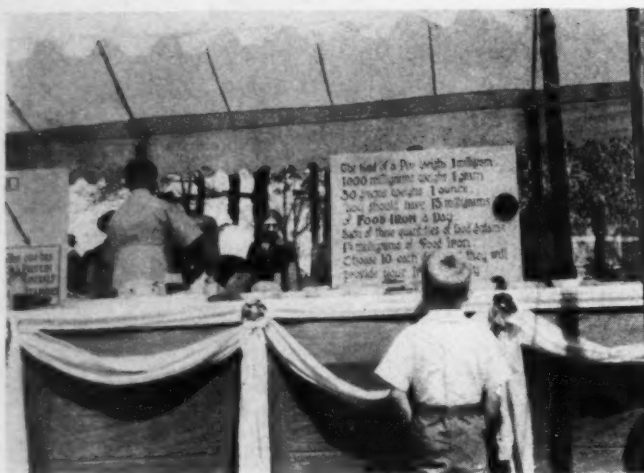
By 8 o'clock that evening the hospital had reverted to normal again when the 2,500 New Englanders had gone back to their homes, informed as to the value of the institution within their midst.

Such an attendance is not brought to an observance of this nature, even though the institution may cover a densely populated area, unless an effective publicity program has been worked out before hand.

Only a moderate expenditure was allowed for Hospital Day publicity at the New England institution. Five types of mediums were decided upon by the committee: word of mouth, signs, posters, written invitations, and newspaper publicity. The committee members included Mr. Cone, Clebern S. Edwards, the assistant director

Part of the day's festivities at New England Sanitarium and Hospital was this nurses' drill. The hospital grounds were in perfect condition and the whole setting was ideal for an event that attracted fully 2,500 guests from all over New England.





Boy visitor trying to assimilate dietetic poster.



There were a baby clinic and a baby reunion.

of the health extension service, and Howard A. Munson, the purchasing agent.

Announcements were made in seven ways:

1. A radio talk over Station WORL, Boston, by Dr. H. S. Brown of the medical staff.
2. Announcement to the civic clubs of Stoneham, Medford and Wakefield, Mass.
3. Each hospital employee was furnished with material about the program and asked to tell all people with whom he came in contact. Outpatients were informed by the nurses' office.
4. Each minister in the community and surrounding towns was personally invited and was asked to announce Hospital Day before his congregation.
5. The Seventh-Day Adventist denomination, with which the hospital is connected, published stories about the hospital in its church paper, which covers New England and New York State, and each minister announced the affair.
6. The chairman of the Hospital Day committee spoke before a number of public gatherings before the celebration.
7. Verbally invited were 106 courtesy staff members.

Signs, posters and written invitations contained a variety of novel ideas.

Signs, made by a member of the hospital committee, were placed at the main entrance of the hospital grounds and in the hospital lobby and nurses' chapel.

Approximately 300 posters, obtained from a hospital supply company, were used to cover a wide area, largely in commercial centers.

Commercial novelties included gummed stickers for outgoing mail, free invitation postal cards for patients' friends, milk bottle collars, patients' tray folders, printed programs, special invitations by letter, printed invitations and 500 invitations to babies born in the hospital.

A movie trailer was shown in a local theater.

Newspaper publicity was roughly divided into news and editorials, the news comprising the bulk of the publicity. An aftermath of publicity was received from the coverage given the affair by both the community's and Boston newspapers. The latter sent a staff of news photographers to photograph babies.

Less Than 100-Bed Class

(Continued from page 64)

born in the hospital during the year. Parents were asked for pictures of the babies and in cases in which no photograph was available, the local photographer was sent to take a picture of the baby. Prizes were given the ten contestants polling the largest number of votes from the visitors. The pictures and prizes, contributed by local business men and baby products companies, were displayed at the registration desk at the entrance, and as visitors registered they were asked to vote for one of the contestants.

Approximately 1,500 visitors viewed the exhibits between the hours of 1:00 and 4:00 p.m. and between 7:00 and 8:30 p.m. as the result of this publicity program. The guests were taken on tours through the hospital by the nursing staff and equipment was displayed and demonstrated.

Interest evinced in the hospital following Hospital Day equaled that prior to the day in local newspapers. The day following the observance the Kiwanis Club devoted its entire program to a discussion on the hospital; at the Chamber of Commerce meeting later in the week the subject of the hospital again was brought up, and several ministers devoted sermons to commending the work of the hospital.

Everyday Procedures

Don't take it for granted that routine procedures will be efficiently and correctly done. The commonplace and ordinary duties are often neglected

By JOSEPH C. DOANE, M.D.

THIS article will discuss some of the routine procedures which are practiced throughout the hospital no matter what its size. Often the most commonplace becomes the most neglected practice because it possesses nothing of the unusual and because both its efficiency and correctness are taken for granted. This is particularly true of those procedures that have to do almost wholly with the nursing of the sick. Of the greatest importance, these largely exemplify instructions and orders, often unwritten but frequently standing, which emanate from the physician.

Indeed, as the young doctor departs from the hospital and enters practice he is surprised to learn of necessities which during his internship he had expected as a matter of course would be performed somehow by someone. It is not unusual for these practices to be required of the physician who undertakes to treat a patient outside of the hospital. Hence this subject may interest such readers and the executive of the hospital may find such a discussion useful.

The preparation of the hypodermic tray and the practice of the proper technique in giving drugs subcutaneously are common and yet are among the most important procedures. Almost synonymous with the care of a group of hospital patients is the necessity for the frequent injection beneath the skin or into the deeper tissues of drugs or solutions aimed at meeting some therapeutic indication or at overcoming dehydration or providing nourishment. Millions of hypodermic injections administered during the year in thousands of hospitals in this country do not command the respect which is their due from doctors and nurses.

It is a practice not entirely devoid of danger. For example, the breaking of a needle within the tissues presents a problem which frequently is difficult to solve. As will be attested by the experi-

enced surgeon, removal of the broken needle is far from simple. It is probably an old woman's tale when we hear accounts of the migration of a needle fragment from the arm to the tip of the toe or from the thigh to the mid-brain. Yet an improper hypodermic tray equipment coupled with carelessness in the handling of the syringe and needle may possibly lead to accidents.

The purpose of hypodermic injection may be set down as follows: (1) to obtain the prompt action of a drug; (2) to spare the stomach the insult of handling irritating or objectionable medicines, and (3) to administer a drug when a patient for some reason is unable to swallow.

Set-Up for Hypodermic Tray

A hypodermic tray should possess the following articles, the tray itself being of sufficient size to provide a slotted or divided space to hold each in place: (1) small bottle of water, this water to be sterilized each morning and the bottle to be dated; (2) alcohol lamp; (3) matches; (4) a bent spoon or tray; (5) receptacle for waste; (6) jar for alcohol sponges; (7) forceps in a jar of 2 per cent solution of liquor cresolis compositus; (8) hypodermic syringe and 70 per cent alcohol in enamel container; (9) needles in enamel container; (10) bottle of 3½ per cent to 5 per cent tincture of iodine; (11) applicators, and (12) necessary drugs.

Search and experimentation have been employed to devise the ideal hypodermic tray. Each hospital is likely to employ variations of the foregoing equipment but, irrespective of what agent is used for sterilizing the skin, the equipment is essentially as listed.

The use of an alcohol lamp on the tray possesses its elements of danger. In the department office the nurse's work table is often provided with a gas flame and the alcohol lamp has been discarded. Burning alcohol to sterilize water has caused fires. This possibility the nursing department is wont to point out forcefully to the young probationer. A careful and meticulous technique should be taught.

The thorough boiling of water in the spoon without boiling the drug to be used, the cleaning of the syringe so that a few drops of alcohol are not given by injection—a most painful error to the patient—are important steps in technique.

Insofar as the cleansing of the skin is concerned, it should be recalled that medical literature abounds in instances in which serious conditions such as tetanus or gas bacillus infection have followed a hypodermic puncture. The slight withdrawal of the plunger before the drug is injected will prove that the needle has not entered a vein and hence that the solution is being given into the tissues instead of intravenously.

If medication is to be given intramuscularly, the technique is the same except that a longer needle is employed and the puncture is made more nearly at right angles with the skin.

Some efficient method should be worked out to prevent the internal rusting of the needle and hence the weakening of the shaft so that it will be likely to break in the patient's tissues. A high grade needle should be purchased.

In cleaning the syringe, it is usually rinsed with water and then placed in alcohol. The needle is dried thoroughly and its wire replaced. It is well to have hypodermic trays originate in the central service station or else have this department responsible for the periodic sterilization of needles and syringes.

Laying down an expensive syringe which contains blood for a few moments before cleansing it is a careless habit. The plunger is likely to set within the barrel, and much difficulty will be experienced in separating the two if, indeed, it can be done at all.

Warnings to Be Observed

Certain precautions in the giving of drugs by hypodermic injection may be pointed out. Bottles containing tablets of strychnine, morphine or other drugs should not be shaken because the contents are easily broken, and hence the dosage is altered. Needles should be discarded when points become dulled or bent. It rarely pays to sharpen them. In giving two drugs by the same hypodermic injection, care should be taken not to spill the first while the second is being drawn into the syringe. Digitalis, mercury, quinine and ergot are best given somewhat diluted because they are irritating to the tissues. They should not be injected superficially. When protamine insulin and the regular insulin are being injected at the same time they should be administered through two separate punctures at least 2 inches apart. This is so because in mixing these agents in the same syringe or even in the tissues the

regular insulin is changed to protamine insulin. Alternation in the limb selected for frequent injections should be practiced. Frequent inspection of hypodermic trays for completeness and proper condition is indicated.

The following is the procedure for catheterization either for removing urine from the bladder when the patient is unable to void or for obtaining a sterile specimen of urine for examination. A sterile tray should contain the following: (1) four small basins in which are to be found green soap, sterile water, bichloride of mercury solution 1/5000, twelve cotton pledgets and two gauze sponges; (2) a basin with compound solution of cresol, 2 per cent, for nurses; (3) a kidney basin; (4) an oval basin containing two rubber catheters wrapped in gauze; (5) three towels; and (6) a sterile bottle for specimens desired and the following unsterile articles—kidney basin, chest blanket, case containing two sterile gloves and forceps in jar of 2 per cent compound solution of cresol.

Catheterization a Serious Matter

This catheterization tray may be altered to suit the peculiar needs of any hospital, but the articles and solutions required are standard. The after-effects of improper or unsterile catheterization may prove serious to the patient. In fact, the ease with which a bladder is infected often brings about a great hesitancy on the part of the physician to permit a bladder catheterization. This is true in patients of all ages but is particularly so in those of advanced years with lowered resistance.

Catheterization of the patient, then, is an important and serious matter. Its possibilities for injury include: the breaking of a glass and the leaving of a section in the urethra or in the bladder; the transmission of infection from without to the bladder wall (cystitis), and the creation of a catheterization habit which tends to lower the ability of the patient to void voluntarily.

During a catheterization the hands of the nurse should be sterilized as carefully as for a surgical dressing or operation. Sponges should be handled with forceps and the tissues about the urethra should be cleansed meticulously. After the field has been prepared, the nurse immerses her hands again in 2 per cent compound solution of cresol and dons gloves before inserting the catheter. All these precautions should be taken to safeguard the patient and they are doubly necessary if a sterile specimen of urine is sought.

Measurement of the urine obtained is important. If a male catheterization is to be performed, added to the tray will be a sterile glass irrigating syringe, a basin of 2 per cent boric solution or

a dilute solution of potassium permanganate, as the physician may order. In addition, sterile vaseline, olive oil or mineral oil, silk or linen catheters placed in bichloride of mercury 1/5000 solution for ten to twenty minutes and two basins of sterile water are provided. These catheters are rinsed in sterile water before use.

Glass catheters are often employed particularly in the female, but there is ever the danger of breakage. They are rarely used in the psychopathic, nervous or pregnant patient. Before a catheter is employed it should be carefully inspected for roughness or cracks which might indicate its liability to break or injure the patient.

One of the primary lessons which is learned and then as quickly forgotten by both young physicians and nurses is the detection of an over-distended bladder in the very sick patient. A standing order usually exists that when a patient fails to void for eight to ten hours in any of the wards of the hospital, the physician is to be notified. The nurse never catheterizes without a written order.

Bladder Instillation and Irrigation

In bladder instillation and irrigation, the same type of tray is used as is employed for catheterization with certain modifications. Added to such a tray are a sterile funnel, a piece of rubber tubing about 14 inches long and a glass connecting tube. In addition are a receptacle for the return flow, a pitcher with 3 or 4 pints of sterile solution plus such solutions as may be specifically ordered, such as normal salt, 2 per cent boric acid and 1/10000 silver nitrate solution. In a bladder irrigation the temperature of the solution is usually from 105° to 110° F. Care must be taken to avoid over-distending the bladder and the mistake of using a too concentrated solution.

In bladder instillation, which implies the leaving of certain medicaments in the bladder following catheterization or irrigation, the solutions commonly used at a temperature of from 95° to 100° F. are from 2 to 5 per cent argyrol, 1 to 5 per cent mercurochrome, 1/4 to 1 per cent protargol and 1/5000 to 1/3000 potassium permanganate solution. The tray for the latter procedure includes, in addition to that for catheterization and bladder irrigation, a sterile instillation syringe and a sterile medicine glass containing the prescribed medication.

In some institutions this type of procedure is performed by the resident physician and not by the nurse. There does not seem, however, to be any good reason why the proper technique cannot be taught the nurse and why she may not do this work with complete safety to the patient.

The purpose of colonic irrigation (enteroclysis) is to cleanse the colon of irrigating material, to relieve thirst if fluids are administered by the drip method, to lessen shock and collapse by giving warmth to the abdominal organs and to stimulate peristalsis and thus relieve flatulence. While this is a proper and useful method of treating disease, it has fallen into the hands of those who grossly exaggerate its possibilities and profiteer on the gullibility of patients. Many consider it harmful for the patient to undergo a colonic irrigation once or twice a week over a period of several months. In many institutions, the giving of a colonic irrigation is delegated to the physical therapy department where the proper table and apparatus make possible an efficient cleansing of the lower bowel.

Technique of Colonic Irrigation

The average colonic irrigation given by a pupil nurse in a hospital bed is likely to be but an irrigation of the lower foot or two of the colon and to be neither pleasant to the patient nor efficient. It is best, therefore, for this type of work to be performed on a specialty table by one who is particularly trained in carrying it out.

The colonic tray, if this work is to be done in the ward or room, contains the following: (1) two large pitchers containing solution at 116° to 120° F., from 2 to 3 gallons of solution as ordered (generally 2 to 5 per cent normal salt solution); (2) an irrigating can with tubing; (3) two clamps; (4) one basin and two rectal tubes (one large, one small); (5) toilet paper with vaseline; (6) paper bag; (7) connecting tip; (8) Y-tube; (9) kidney basin; (10) thermometer, and (11) towel. Other articles needed are a blanket, rubber sheet, irrigating stand, Kelly pad, foot tub, floor rubber and an enamel bucket.

The irrigation should be administered slowly, and if the patient complains of abdominal pain, the ingress of fluid should be stopped temporarily. If the pain continues, the physician should be notified. If the patient shows signs of exhaustion or of circulatory disturbance, the treatment should be interdicted. If a Y-tube is used, only one catheter will be needed. One piece of rubber tubing connects the irrigating reservoir with one limb of the Y and the other piece of tubing leads from the other limb of the Y to the enamel bucket for the return flow.

Such a simple procedure as the irrigation of the colon would seem to require no space for discussion, but as has been indicated, the average colonic irrigation is little more than an enema. Only the fact that this type of work is so often improperly performed, justifies writing about it.

Mrs. Brown Enters a Nursing Home



By LEROY WINDER

Shady avenues through gardens lavish with flowers, and benches inviting one to rest for a moment lure patients outdoors and repeat the cheery atmosphere of the interior at the King's Daughters of California Home for Incurables at Berkeley. Above, a view of the front entrance.

THE institutional nursing home, although it occupies an important part in the care of the convalescent and chronic patient, seems to be little known to the general public and is apparently unfamiliar to the majority of the medical profession. There are several reasons for this. One is that there are few recognized homes throughout the country that have been established long enough to build themselves a merited reputation. The lack of knowledge and complete understanding of how these homes are organized and operated is another. Still another is the fact that many doctors do not know of the existence of such institutions even though they may be located directly in the path of the doctor's daily trips to and from his office.

We all recognize the hospital as the proper place for a patient needing surgical or specific medical treatment, but when this hospitalization is no longer necessary and the patient still needs certain nursing care which might be quite difficult and inconvenient to administer in the private home, the nursing home offers the solution to the problem.

The nursing home may also provide a permanent residence for certain incurable conditions,

such as paralysis, chronic arthritis, various forms of sclerosis and the many types of cases that could not be conveniently cared for at home, such as those needing constant nursing care. Smaller nursing homes or those specializing on some particular form of treatment may confine their activities to one type of case only, while others will extend their field of operation to include blindness, mental senility, carcinoma and tuberculosis when the home is properly located and equipped for the isolation of such patients.

The exact types of cases admitted to a nursing home will depend on the individual home, according to its facilities and equipment, desire to specialize and perhaps its desire to confine its activities to certain fields of operation.

As an example of the usefulness of a nursing home in time of need, we may take the hypothetical case of Mrs. Helen Brown. She has had two previous light strokes, recovering nicely from both. At the age of seventy-two she has had a cerebral hemorrhage with a complete paralysis of the left side as a result. After a week in the hospital, nothing further can be done for her except rest and quiet, so the husband decides that he may as well take her home.

Here is where the trouble commences. Since Mrs. Brown is unable to take care of herself, it will be necessary to employ a nurse or nurses to be with her constantly, as well as someone to do the housework. Mr. Brown, working for \$25 per week, has spent for his wife's illness what few dollars they have saved and to carry out a program of home nursing would be impossible on his income.

Mr. Brown Reaches a Decision

He finds that he can place his wife in a nursing home where she will have every comfort and convenience of her own house, in addition to excellent nursing care. He also finds that the cost will be moderate enough so there will still be a balance left from his wages to allow him to care for himself in a modest way. What a burden off his shoulders and a load off his mind! At his age, he is not equal to the responsibilities of caring for a sick wife at home. Hence, his relief when the nursing home assumes that responsibility for him. This may be a slightly exaggerated case, yet there are many instances similar to this where an accredited nursing home has been the answer to someone's call for help.

A well-organized nursing home should be under the management of a competent superintendent

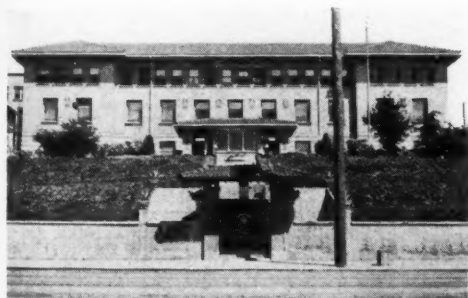
who has had hospital training, is equally qualified in business and engineering to supervise construction and maintenance and who can assume the responsibility of purchasing the proper food and supplies for an economical administration. It is equally important that he have a thorough understanding of the cases admitted to the home and that he should personally see the patients regularly to be sure that they are entirely satisfied with their surroundings. He will often be called upon to settle little disputes and pacify petty grievances. There is no substitute for a personal visit from the superintendent when there is a fault-finding patient to satisfy or a final decision to be rendered.

The nursing should be under the supervision of a well-qualified graduate nurse, who has had sufficient experience with patients of this kind to enable her to assume complete charge of the actual medical and nursing care provided for them.

Patients Need "Mothering"

Assisting the nurse should be her floor supervisors, of course, but the actual care of the patients may be satisfactorily given by undergraduates or practical nurses, inasmuch as the patients' care, where there is no medical or surgical treatment involved, depends more on the nurse's ability to "mother" the patient than on her knowledge or qualifications as a trained nurse.

All employees should be selected for their kindly attitude toward those permanently afflicted. About 50 per cent of the chronic cases found in a nursing home will show a tendency toward mental deficiency. This condition is especially prevalent in those patients past seventy years of age. There is a natural tendency on the part of the patient at



A stairway climbs steeply from the street and is set off with a wrought iron railing (above). Garden shelters have sliding doors that are opened wide on fine days to give a view of the garden. Floors are flush with the walks for the convenience of infirm and wheel-chair patients.



that age to be childish, or set in his ways, making it necessary for those having any direct contact with him to exercise the utmost diplomacy and tact in whatever they do or say.

Cases of this kind are not in the nursing home for a week or two, as in the majority of hospital cases. Instead they usually come to stay for months and sometimes years. In one home a woman has been a patient for thirty years, one man for eighteen years, and many others from two to five years. Consequently, in order to establish and maintain that friendly and homelike atmosphere so necessary for the peace and comfort of the patients, every effort must be exerted to create a harmonious and cooperative spirit between patients and employees, maintaining at the same time the discipline necessary for the perfect functioning of a well-organized routine. Employees, then, should be impressed with the necessity of working with the home instead of for it.

Many years of experience have demonstrated that it is not practical to have wards in the nursing home. Rooms containing two beds may be used to some degree of satisfaction but any more than that are out of the question. When a patient enters a nursing home, he generally does so with the idea of making it his home for an indefinite period. It is only natural then that he should want a room of his own where he may feel free to do more or less as he pleases, without the possibility of disturbing someone else or of being disturbed by a roommate. Some want to read at night; others do not. Some want the radio on for certain programs; others do not. Some like lots of air and want all their windows open, while others prefer a warmer atmosphere.

Homelike Atmosphere Is Best

Make the room as homelike as possible by the use of plenty of color in decorating and by adoption of regular bedroom furniture instead of the regular hospital furniture, and encourage the patient to bring in as many of his personal pictures or as much bric-a-brac as space permits. Hospital beds are necessary in some cases in which the patient is confined to bed permanently, but if he is up and out of bed each day, it will be found more satisfactory to use a low bed as this is more convenient for the older people to get in and out. Each patient has his own ideas concerning certain equipment and furniture to be used in his room and his wishes should be respected insofar as possible.

The serving of proper food is another problem different from that of the hospital. One of the principal difficulties encountered in diets for the older chronic patients is the fact that many of

them have poor teeth, or none at all. For that reason much puréed and ground food is required; all hard foods requiring any great amount of mastication should be avoided. Because of the gastric acidity common to these cases, care must be exercised to avoid excessive use of acid-forming foods.

The planning of tasty and appetizing meals is no simple matter, especially since many of the patients are in the home because they have overindulged in the past. They cannot seem to understand why they should not continue to eat and drink the very things that led to their present physical condition.

How Many Are Needed?

Every city of 50,000 or more population needs a nursing home sufficiently well organized and managed so that it can be recognized and accepted by the medical profession. One bed to every 2,000 persons is a conservative estimate and one that should produce a satisfactory income. It would serve a humanitarian purpose for the community and would permit doctors to follow up more thoroughly the welfare of their patients after dismissal from the hospital, by centralizing their activities.

Many a patient is dismissed from the hospital and the case is closed by the attending physician because apparently there is nothing further that can be done to effect a cure. Thus the patient goes home to sink into oblivion and wait with patience until the end comes. The family may try to do everything within its knowledge and power to make the last days as comfortable as possible, but how many homes are adequately equipped to give the proper service and how many families have the necessary amount of time, without employing additional help, to care for the invalid?

Would it not be far better to have the patient in a qualified nursing home where there is every convenience, where wheel chairs can take the patient out into the sunshine and flower garden? Atmosphere and nature often work wonders and even though the case is recognized as incurable, there is no reason why he or she cannot have the privilege of enjoying what little time there is left.

The nursing home can be operated at a lower cost per patient day than the hospital for many obvious reasons. It is only natural, then, that in cases of prolonged or chronic illness the patient's family, often financially unable to bear the burden of extended hospitalization, will gladly accept the accommodations of a reputable nursing home. There the financial load will be lightened and the responsibility shifted to the shoulders of those who make a business of accepting other people's cares and worries occasioned by illness.

Time Out and the 1938 Budget

MANY hospitals will doubtless revise their vacation policies for 1938. The best time to plan for this is before the 1938 budget is adopted, although no budget should be allowed to stand in the way of liberalizing personnel relations when the hospital can afford it.

As a guide to other administrators three carefully formulated vacation policies are presented herewith.

Each hospital, in drawing up a vacation policy, should be guided by the experience of other hospitals, by the practices of industry in the community and by the benefits that may be expected in increased productivity of employees. Furthermore consideration should be given to the employees' present and probable future demands and the effect of the proposed vacation policy upon employee morale.

Recommendations of the Cleveland Hospital Council have been approved and recommended for adoption on January 1.

Under the Cleveland plan, all hospital employees are divided into four groups, namely, those to receive vacations of 7 to 10 days, of 10 to 14 days, of 14 to 21 days and of 21 to 28 days.

Vacation policies of the Cleveland Hospital Council include the following provisions:

"Insofar as possible, vacations should be scheduled during the period from May 15 to September 15.

"Vacations are granted to prepare an employee for subsequent service, therefore terminal vacations should not be granted. Vacation periods shall not be extended because a holiday occurs during a vacation period. If an employee resigns from the institution within three months after completing a vacation period granted with pay, an amount equivalent to pay granted for vacation period shall be deducted upon his resignation.

"Members of the personnel shall not engage in any other work during a period of vacation

granted with pay, except by written permission of the administrator.

"Vacation assignments should be submitted in triplicate by the department head to the director for approval. The original should be retained in the director's office, the duplicate forwarded to the paymaster and the triplicate returned to the department head after approval by the administrator.

"Vacations shall be granted to all persons on the payroll three months prior to May 15 on the following basis, *i.e.* one-twelfth of the scheduled vacation for each month prior to May 15, up to one year of service.

"Split vacations should not be permitted except by special permission of the administrator, and in no event should the vacation schedule of any worker be divided into more than two periods."

An especially interesting vacation policy for a government-owned hospital has been adopted by the Duval County Hospital, Jacksonville, Fla., described by the superintendent, Fred M. Walker, F.A.C.H.A.

"Vacations may be designated as rewards for

past service or they may be regarded as periods of preparation for a continuation of work. They represent administrative problems and complications; this is particularly true in public hospitals.

"The administrators of public institutions have indicated their earnest desire to deal justly with employees, and to arrange schedules of vacations and sick leaves which compare favorably with those of private hospitals. The latitude of their generosity, however, may be restricted by the public aspect of all their planning. Budgets must be reviewed and approved by public officials who may not be disposed to authorize absences of

When a football coach calls a rest period for his team, he wants his men fresh for the next play. So it is with hospital administrators, who have recognized liberal vacation policies as a means of obtaining personnel support and increased productivity

four weeks or a month, with pay. Funds allocated arbitrarily to detailed classifications may not permit the engagement of relief personnel in vacation seasons.

"Having been confronted with these and other similar public considerations in the course of the last fifteen years, we have devised and used a com-

paid illness is deducted from accrued sick credit, and unused remainders are combined with subsequent vacations.

"This system of sick leaves, which supplements vacations, is accepted by the board and the public because it rests upon the understanding that the beneficiaries of it shall relieve each other in all

RECOMMENDED VACATION PERIODS APPROVED BY THE CLEVELAND HOSPITAL COUNCIL

Group I (7 to 10 Days)	Group II (10 to 14 days)	Group III (14 to 21 days)	Group IV (21 to 28 days)
Pages	Typists	Electricians	Secretary to ad-
Cleaning maids	Stenographers	Plumbers	ministrator
Porters	Secretaries	Electrical engineers	Office manager
Janitors	Junior clerk-typists	Ass't supervisor of	Auditor
Sewing women	Senior clerks	dormitories	Chief admitting
Shade cleaners	Billing machine	Pharmacy helpers	officer
Wall washers	operators	Ass't pharmacist	Purchasing agent
Laundry workers ¹	Bookkeepers	Pharmacists ¹	Head laundryman
Elevator operators	Telephone operators	Nursing maids	Chief engineer
Laborers	Collection clerks	Orderlies	Supervisor of main-
Yardmen	and officers	General duty nurses	tenance service
Gardeners	Cashiers	Ass't head nurse	Supervisor of
Watchmen	Admitting clerks	Resident staff	dormitories
Truck drivers	and officers	Medical records staff	Chief pharmacist
Auto mechanics	Hostess	Medical stenographer	Ass't supervisor
Room maids	Reception clerks	Anesthesia mechanic	of nurses
Gauze women	Night clerks	X-ray technicians	Head nurses
Glass cleaners	Receiving clerks	and technical	Nursing supervisors
Dieters	Stockmen	assistants	Nursing instructors
Dishwashers	Storekeeper and	Laboratory techni-	Ass't superintendent
Waitresses	assistant	cians	of nurses
Dietary maids	Ass't housekeeper	Chemists	Chief therapist of
Servers	Housekeeper ¹	Special therapist	special depts.
Deliverymen	Laundry forewomen	and attendants	Dietitians
	Firemen	Assistant cooks	Ass't supervisor of
	Steam fitters	Pastry cooks	dietetics
	Ass't engineers	Cooks	Senior social
	Heating engineers	Assistant dietitian	workers
	Carpenters	Junior social workers	Ass't supervisor of
	Painters	Out-patient em-	social work
		ployees ²	Supervisor of out-
			patient dept.

¹ Except chief.

² Except pages and supervisors.

bination vacation and sick leave system that has worked successfully without unfavorable reaction or criticism.

"We accept the fundamental principle that any employee of the upper classifications is entitled to a total absence of twenty-eight days in the course of a service year, without sacrifice of pay. Thereupon, we announce maximum vacations of fourteen days, and at times arrange relief service in the course of them. In addition we give our employees an opportunity to earn sick leave credit at the rate of fourteen days per year, or one and one-sixth day per month of service. In case there may have been no enforced absence because of illness, all accumulated sick credit of the next preceding annual period is allowed in connection with the current vacation. Thus, employees who have missed no time at their work may have a continuous absence of twenty-eight days in a regular vacation season. Similarly, each day of

periods of individual sick leave without any assistance from extra personnel. Thus, assurance is given that all of the essential work of the hospital shall be covered without added expense.

Length of Service Is Determining Factor

"Graduate nurses, technicians, dietitians, pharmacists, social workers and office employees are entitled to two weeks' vacation with pay during the vacation season after they have completed one year of service. Engineers, seamstresses, cooks, orderlies, maids and that class of 'help' get a two weeks' vacation with pay only after they have completed five years of continuous service in this hospital. No specific allowances of sick credit are provided for this second class of workers, although in times of illness they may receive individual consideration.

"The details of the system require maintenance of accurate individual time records. These repre-

sent, however, no new feature of an efficient administrative office, and are regarded as essential records of extended general value.

"As we contemplate the experience of past years in municipal and county hospitals, we are convinced that our system of combined vacations and sick leaves is particularly adaptable to them. It specifies the total amount of paid absences per year impartially. It makes them comparable to those of private institutions. It encourages regularity of attendance at work because of a disinclination to sacrifice days of leave in connection with vacations. At the same time employees have comfort and satisfaction in the knowledge that they may be absent as many as fourteen days per year in case of sickness without pay deductions."

Outlines Vacation Policy

The vacation policy of Children's Memorial Hospital, Chicago, prepared by Mabel W. Binner, superintendent, and approved by the board, is outlined as follows:

"Every effort will be made to grant holiday privileges to as many employees as possible on legal holidays. Employees will not be relieved from responsibilities or permitted to enjoy holidays to the number that will interfere with the care of patients.

"The holidays recognized by the hospital include New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day.

"Vacations will be taken between May 1 and September 30, unless it is to the interest of the hospital that certain vacations be taken at other times. Vacations will be granted only to those persons who have been in the employ of the institution six months by the first of September.

"The dietitian, housekeeper, social workers, nurses and anesthetists who have been on full-time duty for one year or more will be allowed four weeks' vacation. If they have been in the employ of the hospital less than twelve months, one week's vacation will be granted for each three months of service.

"The clerical staff, laboratory technicians and druggist on full-time duty for one year or more will be allowed two weeks' vacation. Those in the employ of the hospital less than one year and eligible for a vacation will be allowed one day for each month of employment.

"The chief engineer will be allowed two weeks' vacation if in the continuous employ of the hospital for one year.

"All other employees will receive one week's vacation on pay after one year on full-time service. A second week without pay may be taken.

No other leaves of absence will be granted during the year. Two weeks' vacation on pay will be granted after five years' continuous service. Household help employed for more than six months and less than one year may take one week without pay.

"A total of six days' sick leave with pay will be granted each year. This leave is not cumulative and may not be exceeded except in rare cases.

"No other leave of absence, with or without pay, will be granted except for the purpose of study or extensive travel, which could not be covered during a regular vacation.

"Vacation periods are granted not as a bonus, but as a preparation for future service. Employees are expected to return to the service of the hospital for three months after the expiration of vacations. No vacation or part of any vacation salary will be granted otherwise.

"Members of the intern staff will receive two weeks' vacation at any time of the year, except during June, July, December or January, when it can be arranged most satisfactorily by the hospital. The time must be approved by the superintendent and chief of staff. Each intern is expected to see that his service is covered during his absence."

Do You Investigate Applicants?

Some hospitals carelessly employ applicants for positions without first checking their records. Employees who have been discharged by one institution for serious offenses have sometimes been hired by others who have not taken the trouble to check their past performances. More serious is the fact that employees with criminal records have occasionally been placed in somewhat responsible and trusted positions in hospitals solely because their records were not checked.

The plan of having the police check and report upon such applicants is used extensively by one nationally known taxicab company. If hospitals would adopt such a plan they, too, could determine whether or not their employees should be placed in positions of trust.

One hospital recently hired a man who had been judged guilty and sentenced for forgery. At the first opportunity this employee stole some of the hospital's pay roll checks and, forging the superintendent's name, passed a number of them before he was caught. If the hospital had known his past record, and had still wished to hire him, he might have been placed in a position that carried no opportunity for temptation.—*Frank J. Walter, St. Luke's Hospital, Denver.*

Combating Cancer



Out-patient corridor



Corner of laboratory



X-ray machine

Last year 5,000 patients were examined in the new Pondville out-patient section.

New shockproof deep therapy x-ray equipment at Pondville.



Patient's room

CANCER is now second only to heart disease as a cause of death. Practically every case at some time should have hospital care, yet the highly specialized treatment necessary is beyond the means of a large proportion of the population. These facts place cancer in a unique position as a public health problem.

It was consideration of these facts together with the constantly increasing demand for an institution in which large numbers of indigent cancer patients could receive the benefits of radium and x-ray treatment as well as surgery, that led to the establishment of a state cancer hospital in Massachusetts.

Massachusetts was the first state in the United States to appropriate funds from the state treasury for the purchase and maintenance of a hospital to be used solely for the diagnosis and treatment of cancer.

For many years persons prominent in public and private life had been interested in the cancer problem and had worked for its solution, but it was not until the years 1925 and 1926 that the bill was filed that actually resulted in the establishment of the much desired hospital. This bill recommended that a sum of \$1,500,000 be appropriated for the construction of a hospital in Boston, but when the time came for the money to be appropriated it had failed to be included in the budget.

An amendment was then offered providing that a group of vacant buildings known as the Norfolk State Hospital, located near Wrentham, Mass., be utilized and that \$100,000 be appropriated to recondition them. This bill was signed on May 29, 1926, by Governor Fuller, and the Norfolk State Hospital, later named Pondville Hospital, was opened for patients on June 20, 1927, with a capacity of ninety beds.

Today the Pondville Hospital has a capacity of 147 beds. These beds are in pavilions, each having single rooms and several two and four-bed wards. Large, airy porches, comfortable rooms, necessary diet kitchens, and adequate and co-operative nursing service, in fact all services that

at Pondville

By GEORGE L. PARKER, M.D.

help to make a person comfortable when he is ill and away from home and friends, are included in these pavilions.

There are four operating rooms with equipment of the most modern type, two deep x-ray therapy machines, a gram of radium element, numerous radium needles encased in platinum and an electrosurgical unit. There are chemical, bacteriologic and pathologic laboratories, and a medical library. The hospital has been approved by the American College of Surgeons.

An unremunerated advisory committee, representing the three medical schools in Boston, gives no actual service but furnishes advice as to the general therapeutic policies of the hospital. The visiting staff, composed of twenty-four men, representing all the medical and surgical specialties, receives salaries. Many of these men devote two half-days a week to the work of the hospital, others, one half-day, while others are called as the occasion arises. These men are all working on cancer in other institutions and are deeply interested in its problems. The resident staff consists of the medical superintendent, who lives on the grounds, and nine resident physicians, all men who have graduated from surgical or rotating services of general hospitals.

One of the important services of this hospital is the general clinic which is held every Thursday afternoon from 1 to 3 p.m. This clinic is for new patients, ambulatory patients and follow-up work. Anyone who lives in Massachusetts may visit the clinic for a diagnosis. Here consultations are held by groups of visiting men. A radiologist, an intern, a dentist and a laboratory technician are present to make the necessary examinations. No matter how advanced the case or how obvious the condition, thorough examinations by x-ray and other special procedures are made. Special clinics are held on other days by appointment.

During the last nine years the out-patient clinics have increased from fifteen patients weekly to nearly 5,000 patients annually. The Pondville Hospital acts as a nucleus for the sixteen state-aided cancer clinics situated in as many cities and



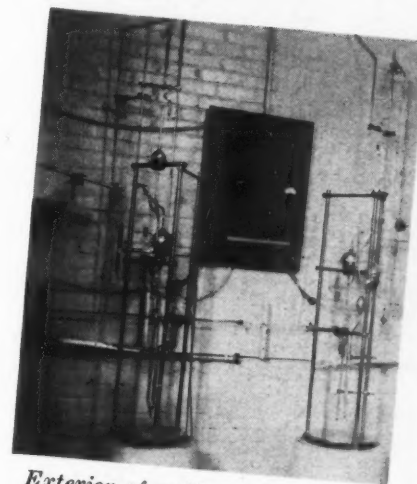
Pondville Hospital

No citizen of Massachusetts, whatever his station, need be deprived of diagnosis and proper treatment for carcinoma.



Ward corridor

The vault at the right contains 10.08 mg. of radium in standard; 9.91 mg. in plaques, and 273.968 mg. in platinum needles.



Exterior of radium vault



Chemical laboratory

towns. Instructions in the diagnosis of cancer are given to the clinic staffs at this hospital. Cases difficult to diagnose are referred from the clinics to Pondville Hospital.

The social service department of the hospital is also an important factor in the work, because in cancer the early diagnosis and treatment are dependent not only upon the doctor's examinations and recommendations as to the treatment but also upon the patient's ability to carry out this advice. These in turn are dependent upon the patient's environment and economic resources. It is here that the medical social service department is of great value.

At the Pondville Hospital, this department serves both the out-patients and the house patients. Because of a long waiting list, an effort is made to have one of our three social workers visit the home of each patient who makes application for admission to determine which applicants are socially in greatest need of the hospital facilities.

Thus the social service department, whenever possible, establishes a contact with the patient before he enters the hospital, assists him while he is in the hospital and performs a valuable service in follow-up after he has been discharged. Uniform records are kept and statistical studies are frequently made.

There is a social service committee, comprised of a group of women from neighboring towns, a local minister and a parish priest, that provides many little luxuries for the comfort of both patients and employees.

Private Room for Every Patient

Admission to Pondville Hospital is limited to residents of Massachusetts who have lived in the state for at least two years of the three-year period prior to the date of application, and requires only the written application of a registered physician. Persons who are able to pay their own bills pay \$10.50 a week, which is all inclusive. If a person is unable to pay, the city or town in which he has a legal settlement is assessed at the rate of \$17.50 a week.

Every patient, whenever possible, regardless of his financial status, is given a single room and as much individual attention as his condition requires. There is no classification of a ward or a private patient. The few two and four-bed wards are for patients able to be up and about. The hospital personnel, from the lowest to the highest, cooperate to give the patient every service and to make him comfortable mentally and physically.

Daily visits are made by priest and ministers from neighboring parishes and current litera-

ture is distributed twice weekly for those desiring reading material. For those who enjoy the radio, bedside earphone attachments are available. Motion pictures are shown bimonthly during the winter for patients who are up and about.

When a patient is discharged from the hospital, he is referred back to his family doctor or the clinic that referred him to the institution. A letter is sent to this person, giving the diagnosis, treatment and prognosis with the advice that there be a continuous follow-up of the patient, both under his supervision and in the out-patient clinic of the Pondville Hospital. In this way, harmony and cooperation are maintained between the hospital and the private physician.

The citizens of Massachusetts, laymen as well as physicians, have become interested in cancer control during the last ten years. This has caused nearly a 46 per cent increase in the demand for beds for cancer patients in general hospitals throughout the commonwealth since the opening of Pondville Hospital.

Records Aid Investigation

When, as too often happens, a complaint or criticism involving the attitude of the hospital personnel toward the patient within its walls or the public without its gates reaches the superintendent, any written record made at the time of occurrence of the incident which gave rise to the complaint is sure to be of value to him in attempting to determine the accuracy of the complaint or the justice of the criticism. Especially is this true if the record is a routine one and hence made without any thought on the part of the person making it that a complaint is likely to be registered concerning the event recorded.

An example of such a record is one kept by a certain hospital where telephone inquiries concerning the condition of patients are answered by a special operator at the hospital switchboard. The record shows the time each inquiry was received, the name of the patient inquired after, the time the person calling was given a report and of what information the report consisted. The record is kept in tabulated form under the following column headings: time, patient's name, person calling, number of call, ward, report, nurse's name, time reported. Complaints of delay or total failure in securing a reply to such an inquiry are readily investigated. Will someone kindly devise a reliable system for determining the validity of complaints of inconsiderate and discourteous treatment?—A. F. Dolloff, Ph.D., *New Haven Hospital, New Haven, Conn.*

The Job of Record Librarian

Why have such a job? What type of person should hold it? What shall her qualifications be? The president of the national association answers

By IRENE M. CONNORS, R.R.L.

THE position as medical records librarian in the hospital has evolved into a definite profession along with the hospital standardization movement and has been further solidified by high educational requirements.

Prerequisites for entering a hospital medical records librarians' training course include at least two years of college work, preferably with the B.S. degree; a background in anatomy and physiology; proficiency in shorthand and typewriting, and a thorough knowledge of Latin.

Personal qualifications are personality, a sense of humor and a neat appearance. The importance of absolute sincerity, along with tact and diplomacy, in dealing with members of the staff, the interdepartmental personnel and the public should not be overestimated. The ability to create harmony and good will among associates always will make a good impression for the institution in the community which it serves.

The librarian should study the doctors' characteristics, learn their pet aversions and idiosyncrasies, learn to respect them, sympathize with them and to make them feel their part in this particular field of hospital organization is the most important of all. The medical records librarian should never make the doctor feel that there is a one-sided obligation to be performed. The doctor should be made to realize that the librarian has obligations just as he does to bring the department to a high standard.

The librarian should never nag the doctor. Conflicts often leave scars that are hard to efface. It is poor psychology to expect the doctor always to be cheerful and willing to do his work. He is often exhausted from overwork and loss of sleep and deeply concerned about his patients. The librarian should, therefore, be persistent but patient in dealing with procrastinations.

This plan should also work out in dealing with the general public. If the medical records librarian adheres to the standardized rule in giving out information, is kind but firm in dealing with attorneys, insurance investigators, health directors and welfare workers, her conduct makes a good impression and often brings additional clientele to the hospital.

Another important factor in recounting the qualifications of the medical records librarian is a progressive attitude. A wider knowledge of the profession may be obtained through reading and through local, state and North American association meetings where programs deal with the solutions of everyday problems that confront the medical records librarian and where scientific papers pave the way for higher education in this branch of hospital activity.

The medical librarian should possess originality and initiative and should be alert to all new ways of improving medical records. Honesty, accuracy and firmness against temptation of any kind that would lead to dishonesty are prime requisites. There is a definite responsibility in dealing with human lives, and an obligation to contribute a share of efficiency to the welfare of patients who have entered the institution.

First Duty to Superintendent

First responsibility in the scheme of hospital organization is to the superintendent. Responsibility for records must be shared by the superintendent and the medical records librarian, because the latter has little, if any, direct control over the preparation of the records. The support of the superior officer as a disciplinarian will coordinate the efforts of the staff member, the intern, the supervisor, the admittance clerk, the pathologist, the graduate and student nurse and all others who enter into the building of the medical record.

The department must be operated in the most efficient and economical manner. It is within the librarian's province to establish, with the approval

of the superintendent and the governing body, a system that is unsurpassed in results. The medical librarian also can collect current medical literature and file it in an accessible manner, abstract and compile bibliographies for the use of the busy surgeon or medical man, and watch for cases that will make interesting case reports for sectional staff meetings.

Next the medical records librarian can devise and execute means for obtaining good clinical records. Here manifold difficulties will arise, probably the greatest being the lack of interest manifested by the intern in getting a good clinical history of the patient. Most interns feel they have served their apprenticeship in this capacity when they have finished the medical college course. They are not record conscious.

It requires constant vigil to obtain histories promptly and to see that they contain all the data necessary to make them of scientific value. The medical librarian must produce an argument in favor of the staff member doing his part of the work in this procedure. It is a splendid plan to point out to him occasionally the fallacy of depending too much upon his intern to perfect the patient's history.

Dealing With Staff Members

If the staff member persists in being careless about supervising the work of the intern in this respect, it is a good plan to watch for an opportunity, and it will come, when the staff member will approach the medical librarian long after a patient has been dismissed, the history has been completed, signed and filed away, and ask to see the history. Perhaps some legal point will be at issue or the insurance cannot be collected because the history states that this patient had attacks over a period of months or years before the operation took place. The staff member now looks at the medical record from a different angle. He probably will say to the medical librarian, "This history is all wrong, this patient never had any attacks prior to the one he had on admittance. This record must be changed!"

It is then that the medical librarian can drive home her point by calmly saying, "I am sorry, doctor, but that patient was in the house three weeks, and the history was written twenty-four hours after admission. Don't you think you had ample time to correct the error you are charging against the intern? You have signed the record and that is prima facie evidence that you considered it correct and complete, is it not?" A few such instances and the careless staff member will become more record conscious.

The better educated the medical librarian is in

appraising the work done on the clinical record, the greater will be the anxiety in securing good records. If thoroughly versed in this work, the librarian will be able to determine without any great effort whether the record is of scientific value or merely wordy. If the history and laboratory findings bear out the diagnosis made by the doctor, the librarian will know if the diagnosis is merely a symptom or the real disease.

After the medical librarian has reviewed the clinical record and supplied all the missing data, the record is signed by the physician in charge of the case, and filed. The summary card is then completed, indexed and cross indexed and made available for future use.

Legal Viewpoint Is Necessary

The medical records librarian must view each medical record from the legal angle. For legal purposes all integral parts of the record must be the original ones, and they should contain no contradictory statements. No information on a record may be given out unless a signed release is made by the patient, legal guardian or parent in case of a minor, and through subpoena. In case of subpoena into court the medical records librarian must be prepared to give intelligent testimony as a protective measure for the patient, the doctor and the hospital.

An efficient medical records librarian is prepared at all times to give accurate statistical reports to the superintendent, the training school for nurses, welfare workers, the board of health, the American College of Surgeons or any other organization that enters into the field of hospitalization.

By means of a monthly analysis report the type of work being done in the hospital is shown. A close watch on house infections, morbidity and mortality will show through the librarian's statistics the percentage of mortality assigned to the hospital, and those cases that come within the twenty-four and forty-eight-hour periods, together with those mortalities that are assigned to the coroner. The report will also show the percentage of autopsies performed.

The medical records librarian also has a place as a teacher in the institution. After the student nurse has been taught the basic and fundamental principles of clinical charting in the training school for nurses, the medical librarian illustrates to her the practical reasons for keeping accurate clinical records and shows her how to do it. In the same manner the medical intern is taught the practical side of keeping medical records.*

*From a paper read before the Minnesota Hospital Association and the Association of Record Librarians of the State of Minnesota, Rochester, May, 1937.

PLANT OPERATION • • • •

Conducted by John R. Mannix and R. C. Buerki, M.D.



Medical Movie-Making

By J. D. Reichard, M.D.

THE motion picture provides an important vehicle for the presentation of medical subjects. Visual presentation with action is a great advance over didactic lecturing, or presentation by the printed page or by a limited number of still pictures. The points to be made strike home with increased meaning and force when presented in pictorial action.

The present article will be confined to the preparation of "amateur" films for silent presentation.¹ There are no good sound cameras for amateur film, and the use of 35-mm. film with sound recording is a highly technical and expensive procedure.

Two sizes of film and camera in the amateur field are available, 16 mm. and 8 mm. The 8-mm. camera is not suitable for serious work. In the 16-mm. field, however, cameras, film and accessories are highly developed, and the worker can do practically anything that is done in the professional field except sound recording.

Absolute essentials for medical cinematography are a camera with suitable lenses, a tripod, an exposure meter and flood lights.

The choice of a camera depends on

the funds available. The apparatus should have (1) a spring motor drive, (2) a finder suitable for the lenses to be used with a correction for parallax,² (3) a turret lens mounting or an extremely simple method of attaching and detaching lenses, (4) an exact film meter, preferably of the audible type, and (5) variable speeds from 8 to 64 frames per second.

The tripod should be sturdy and should have a head equipped for vertical and horizontal movements of the camera with simple locking devices. The tips should be reversible so that, depending on the surface, rubber tips or spikes can be used. A tripod truck, or "dolly," on which the tripod can be mounted, is a great time-saver when the camera is to be moved from point to point.

At least three lenses should be purchased, a fixed focus 15-mm. (wide-angle) lens with an aperture of at

² Parallax is the apparent displacement of an object owing to the actual displacement of the observer. In photography this phenomenon is involved in focusing on near objects, since the viewpoint of the finder is not identical with that of the lens. The axes of the lens systems of camera and finder may be considered parallel for photographing objects at a distance. To secure coincidence of fields of finder and of camera for near objects the axis of the finder must be shifted so that the two axes intersect at the object photographed.

least f.2.5, a 1-inch focusing mount lens with an aperture of f.1.5 to f.1.9, and a 2-inch telephoto focusing mount lens with an aperture of at least f.2.5.

Latitude of film is considerable but not sufficient to allow for serious errors in judging illumination; these are bound to occur even when the worker has had much experience. Hence a photo-electric meter is essential in order to avoid overexposed or underexposed shots.

Medical photography is usually done indoors. The best and cheapest source of light is the photo-flood bulb mounted in a portable reflector. Equipment for at least four and preferably more bulbs will be needed. These lamps are made only for 110 volts. If the current is 220 volts they can be used by connecting them in series, two to each circuit.

In the 16-mm. field "reversible" film usually is used. This is film which, when processed, gives a positive, ready for projection. Films of varying speed and color sensitivity are available, and the choice depends largely upon the character of the work. For indoor work a superspeed film is desirable, and usually a panchromatic emulsion gives the best results. However, when photographing skin lesions in which the reds must be emphasized, an orthochromatic emulsion is preferable.

Photography should be done in a good sized room with fairly light (e.g. buff) walls, broken as little as possible by doors or windows. Intensity of outside light can be ignored, but ventilation should be adequate, as photo-flood bulbs generate much heat.

Lighting is supplied by at least two sets of floodlights, each with two reflectors. One or both of these sets can be "doubled up" by placing a double socket in each outlet. Fuses must be adequate, and it is well to have the electrician at hand until this detail has been settled.

How to Set Up a Scene

Lighting should be arranged so that much more light falls on one side of the subject than on the other; this secures the presence of shadows, which give interest and contour to the scene. The accompanying diagram (Fig. 1) gives an idea as to the setting up of a scene. Placement and distance of lamps must be experimented with until a striking and pleasing effect is obtained. If possible highlights and shadows should come together at the point of interest.

The problem of exposure is not great if a photo-electric exposure meter is used, and if certain fundamental principles are understood. Each lens is supplied with a diaphragm by which the working aperture of the lens, and therefore the amount of light admitted, can be varied. The ratio between the distance from lens to

¹ From the Neuro-Psychiatric Service, U. S. Marine Hospital, Ellis Island, N. Y.

film and the diameter of the diaphragm is known as the "f" value of the lens. It can be seen that the lower this value the more light is admitted and the "faster" the lens is. (This expression has nothing to do with shutter speeds.)

The exposure time in motion picture work is fixed. Working at normal speed, 16 frames per second, the shutter is open approximately 1/30 second for each frame exposed. Therefore, the diaphragm must be adjusted so that too much or too little light is not admitted.

The problem then is to convert the degree of illumination of the subject and the "speed" of the film used into a diaphragm setting. This is simply done with the photo-electric exposure meter. The adjustable scale is set for the speed of the emulsion used, the meter is pointed directly at the part of the scene on which optimum lighting is desired, as close to this part as is possible without shadowing it, the reading taken, and the scale adjusted to this reading. The "f" reading opposite 1/30 second will be the diaphragm setting for the scene.

Focusing presents no problem with the wide-angle (15-mm.) lens. With the one-inch and telephoto lenses the focusing mount must be set as exactly as possible on the distance between lens and subject, when this distance falls within the range of markings on the lens.

The lens must be protected from extraneous light as this will cause



Highlights and shadows are close together at the point of maximum interest. Set the scene first.

board or other suitable object (Fig. 1).

Reflections of lights from walls or other surfaces (known as "kick-backs") must not be within the field. These detract the attention from the principal point of interest and destroy the composition of the scene. Their control presents the greatest difficulty in setting up a scene. Ingenuity must be exercised and sometimes the whole lighting arrangement must be changed.

When possible the camera should be pointed toward a corner of the room (Fig. 1) and subject and lights arranged accordingly. Sometimes a hospital screen can be utilized to cover a kick-back. If the reflection is from a glass door of an instrument cabinet the door can be opened slightly. If it is from a window, the window can be raised or the shade lowered, depending on which will appear more natural.

Moving the camera, i.e. "panoraming," during a scene should be avoided when possible, as a jerky effect is usually obtained. Scenes usually can be planned so that this is unnecessary.

The speed for silent projection of 16-mm. film is always 16 frames per second. If this speed is used in photography, action on the screen will have the same tempo as the original. Scenes photographed at 8 frames per second will, when projected, give an exaggerated and unnatural appearance of speed. However, the 8 per second speed doubles the exposure time and is useful when light is poor. When faster speeds, viz. 24, 32 and 64 frames per second are used, the action is projected on the screen in "slow motion." This is a valuable method of analyzing gaits or very rapid movements. Sound film projectors run at a speed of 24 frames per second. If one expects to have a lecture recorded on the film, the camera should be run at this speed. Diaphragm openings and lighting must be adjusted for the

different speeds. The approximate exposures are as follows:

8 frames	1/15	second
16 frames	1/30	second
24 frames	1/40	second
32 frames	1/60	second
64 frames	1/120	second

Motion picture records of x-ray films can be made for inclusion with clinical data. The film is placed in a mercury vapor view box, and the rest of the view box is blocked off with opaque paper. The exposure time is obtained by placing the meter against the film. During the shot a pointer should indicate the salient points in the film.

To summarize, the following points must be checked before a scene is shot:

1. Exposure time
2. Kick-backs
3. Relation between lights and lens
4. Parallax setting
5. Diaphragm of lens
6. Focus of lens
7. Speed of camera

It is well to recheck items 4, 5, and 6 after the scene has been photographed to be sure that no error has been made.

The equipment necessary for editing is: (1) a pair of rewinds, preferably geared, (2) a film viewer and (3) a splicer. These can be assembled on a stout board, and the assembly, when in use, secured to a table with two C-clamps. With this unit film can be arranged, titles inserted, defective parts removed and length of scenes regulated with a minimum of effort.

Film for projection is assembled on reels of 400 feet capacity. A supply of these, with humidors containers is, of course, necessary.

If a film has permanent value the original should not be used for exhibition purposes, as wear and tear from projection soon will destroy it. Duplicates can be made at reasonable cost. Any number can be made from a film and the original can be preserved under optimal conditions.

When not in use all film should be kept in dust-tight, moistureproof containers. During months when artificial heat is in use, moisture should be supplied. For a considerable amount of film, a large lard can with a tight fitting lid is an excellent humidur. Moisture can be supplied by placing half an apple in the can.

Film should be wiped with a clean soft chamois after each projection, and occasionally should be cleaned by moistening the chamois with carbon tetrachloride. These cleaning procedures are most conveniently done when rewinding. Carbon tetrachloride should be used only in a well ventilated room, as even low concentrations of this substance cause headache and malaise.

One should not try to obtain too large a picture from 16-mm. film. The

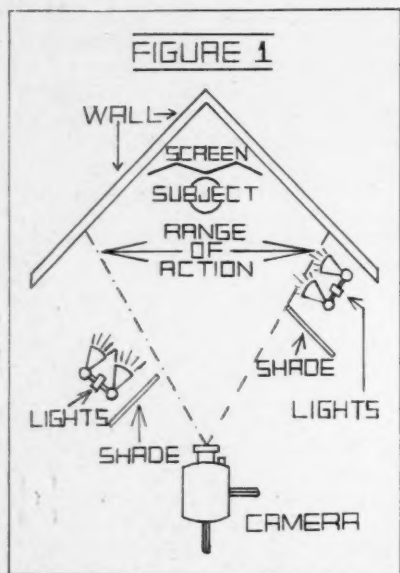


Fig. 1—Showing how to set up a scene for best lighting effects.

fogging and loss of distinctness. In setting up a scene great care must be taken not only that no lights are visible in the finder but that no light can shine on the lens from any angle. If seen in the finder the lights must be moved; if shining obliquely they must be shielded by a piece of card-

Sensitive fire detector doubly safeguards "S. S. Normandie"

FIREPROOF? Of course; but officials of the French Line take no chances with fire on the "S. S. Normandie." First, they built a fireproof ship—decorated with fire-resisting paint. Then, in each cabin, they built a fire detector so sensitive that the slightest abnormal rise in temperature rings an alarm in the ship's central fire station (here illustrated)—and closes all ventilators in the danger zone.



Saftiflasks doubly safeguarded, too!

Despite exacting care in production—no Saftiflask can reach your hands until the lot of which it is a part has been proven safe by rigid chemical, bacteriological and physiological tests put on by testing experts entirely divorced from the production group

As an additional precaution—to give you visible assurance that the solution has not been accidentally exposed to contamination—every Saftiflask is doubly safety-sealed; by vacuum, and by an easily removed viscous seal.

NO MORE COSTLY

Actually, on the basis of direct costs alone, these ready-to-use solutions in Saftiflasks are less costly than those prepared from concentrated ampules. And, when all of the indirect costs are carefully evaluated, they will be found to be no more costly than those prepared from raw chemicals.

Saftiflasks are available from strategically located distributors throughout the country. They are manufactured by Cutter Laboratories of Berkeley, California and 111 No. Canal Street, Chicago. Member of Hospital Exhibitors Association.



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size should be only large enough to be seen comfortably by the entire audience. The smaller the picture, the brighter and sharper the image will be.

For ordinary projection a 2-inch projection lens is standard. If the projection is to be back of the spectators a 3 or 4-inch lens gives much better results. If the projector is to be in front, a wide-angle 1-inch or $\frac{3}{4}$ -inch lens is preferable.

The projector should have a lamp

is being recorded, individual scenes should not be longer than fifteen seconds and the minimum length should be about ten seconds.

Scenes should be rehearsed, and the director must be certain that action is natural and clearly indicates the point to be made.

The use of lenses of different focal lengths during a scene adds greatly to its pictorial quality. For example, the whole setting is registered briefly and then the point of principal in-

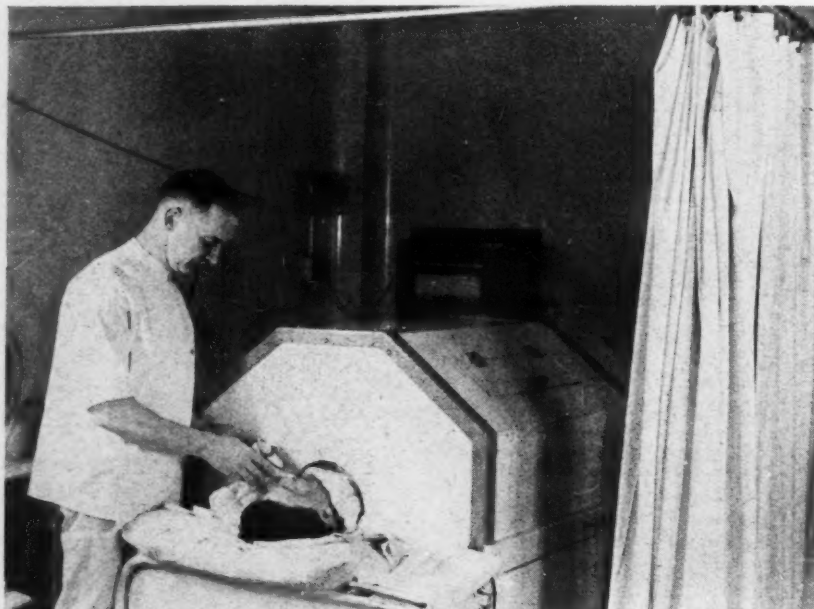
but much work is necessary to produce an artistic job. The simplest plan is to have titles made by a professional. The cost is not prohibitive. For example, for one film recently completed the total cost of titles for 800 feet of film was \$20.

When shots and titles have been assembled, the material is spliced together. A working scenario is necessary, two copies being used. In one the titles, in the other the scenes, are numbered consecutively. The titles and scenes are each tagged with a piece of paper bearing the appropriate number. The titles are then spliced in sequence and then the scenes inserted at the proper places.

After the material has been assembled it should be critically reviewed, preferably with the assistance of someone unfamiliar with the material. Special attention should be paid to length of scenes and of titles, rearrangement of material, alteration of the wording of titles and the addition of supplementary titles.

Amateur films are frequently spoiled for want of drastic cutting. One should, therefore, never hesitate to cut scenes to a length that carries the lesson but does not cause the picture to drag. Remember that others do not have the personal interest in the material that you have, but are interested only in relevant material with a good continuity.

Much medical material valuable for teaching is temporary in character or cannot be brought to a group. Motion pictures make this material both permanent and portable.



To avoid "kick-backs" point the camera toward the corner of the room.

of at least 500 watts; a 750-watt lamp is preferable.

Several points not stressed in instruction books should be emphasized.

Sometimes during projection the even hum of the projector will be broken, a lunatic chattering replaces it, and the picture is replaced by a blur. This is caused by "loss of loop," usually resulting from a broken sprocket hole. The remedy is to stop the machine, open the film gate and readjust the loops. Before the next projection the defective point in the film must be removed.

Another embarrassing occurrence is a break in the film. There are several ways of handling the situation. Very small paper clips may be used to clip the ends together, or the film may be fed into a wastebasket. The simplest method is to pull out several feet of film from the take-up reel, tuck the upper end of the film under this, and then, starting the projector carefully, allow the loose end to overlap the tucked-in end.

Direction is the most important part of making motion pictures, and is unfortunately the most difficult to describe. The purpose of the scene or scenario must be well thought out and a rough draft of the scenario made. Unless very interesting action

interest is photographed with a lens of longer focal length.

If much work is to be done, at least one assistant is necessary. Arrangement of lights and furniture, setting up and operating the camera, directing and checking on all the details, make too much of a load for one person to carry.

Titling is, like direction, an important part of film production and is difficult to present. As in direction, a certain dramatic sense must be developed. Good titling is the corollary to good direction. In direction the scenes should be clear, logical and as brief as possible. In titling, the captions should be simple, concise and forceful. In general, a title should not be longer than twenty words.

A careful balance must be maintained between pictorial material and titles. On the one hand, too many words will bore the audience; on the other, long stretches of scenes without titles will have little meaning. The film should be thought of as a lecture, the titles being the points to be made, the scenes, the illustrations and amplifications of them. A new scene or a new angle must be properly introduced by a title, and supplementary titles used when necessary.

Titles may be made by the worker,

Laugh at Fifty Below

A recent severe winter wrote its history in the cost of heating plants, but nowhere, perhaps, with such pleasure as in Fairbanks, Alaska, where the temperature dropped to 50° F. below zero and remained there for two weeks.

St. Joseph's Hospital had completed an addition in October of that year, and at the same time had installed automatic coal burners to take over the heating of what had become a fifty-bed institution. When the outside temperature took a nose dive, the hospital realized, to its great delight, that it need never know how cold it had become if it stayed inside the building, for the new heating plant maintained a practically unvarying temperature throughout. The heating system is hot water, with two boilers, one in use, the other for emergency purposes. A tank with a capacity of 375 gallons of water is kept hot constantly, furnishing water for baths, laundry and similar purposes throughout the building. "We heated the enlarged building," said the Sister Superior, "with practically no increase in the consumption of fuel."



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Floors and Walls

Making Older Sterilizers Safe

By O. E. Olson

PREVIOUS to 1928, it is probably safe to say that a majority, if not all, nonpressure sterilizers were made with the water supply connections entering from the bottom and with water waste connections entering through a system of closed piping and leaving the sterilizers in the same manner.

It has been definitely established that with certain conditions, it was simple to create a back siphonage of contaminated water into the house water supply. As a result of research by persons investigating these conditions, the sterilizer manufacturers developed various types of water fill fittings attached near the top of the sterilizer and incorporated them on sterilizers built after 1928-29.

However, it is the equipment installed prior to this with which we are concerned. The sterilizers with the old style bottom water fill connection have been put on the spot by the public health departments in many states.

Research into the question of back siphonage of water from a sterilizer has proved that there must be a minimum vertical distance of 2 inches from the top of the sterilizer, or overflow point that cannot possibly be clogged, to the point at which suction into a water supply is set up. In

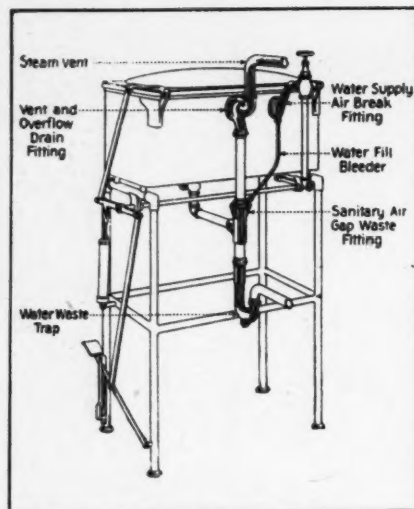


Fig. 1—Instrument sterilizer with air gap waste and airbreak supply.

other words, if the opening into a water supply pipe is less than 2 inches above the highest water level possible in a sterilizer, water from the sterilizer is in danger of being drawn into the water supply line by the suction of the partial vacuum that may be caused in long vertical water supply pipes and contamination results. In order satisfactorily to install the

new types of water fill connections on the sterilizers now in use with the old type of fittings, it is usually necessary to take the sterilizer out of commission. This is not always possible in some busy sterilizing rooms.

There are methods of arriving at a satisfactory solution by changing the water supply piping slightly, thus reducing to a minimum the length of time the equipment is out of service. One simple method that may be used is to have a swinging spout, or goose neck, installed at one end of an individual sterilizer or between two adjacent sterilizers. It should be at a height to clear the covers and when not in use may be placed in a position midway between the sterilizers, with the spout facing forward—or it may be placed just back of and centrally between the sterilizers so it may be swung back to clear the back of the sterilizers.

With this type of fixture one should be careful to get the nondrip type of nozzle. A drip shelf should be added because of the pernicious habits of valves beginning to leak after a time.

Another method is to rearrange the water supply piping to include a vacuum-breaking valve 2 inches or more above the top of the sterilizer. In doing this a "T" fitting should be installed between the vacuum-breaking valve and the sterilizer, so placed that a small tubing drain can be run to the waste piping to carry away the drip from a leaky water supply valve and to prevent raw or unsterile water from entering the sterilizer. Typical arrangements are shown.

The situation in regard to the re-vamping of the waste piping is some-

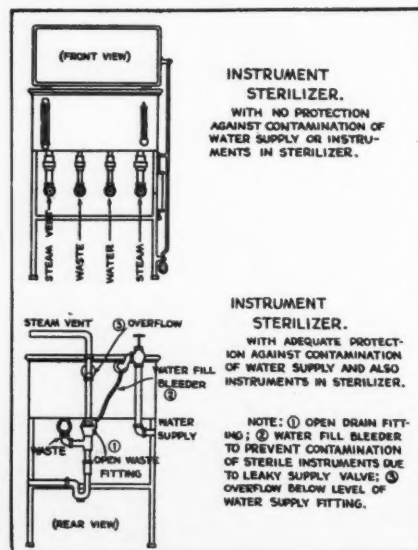
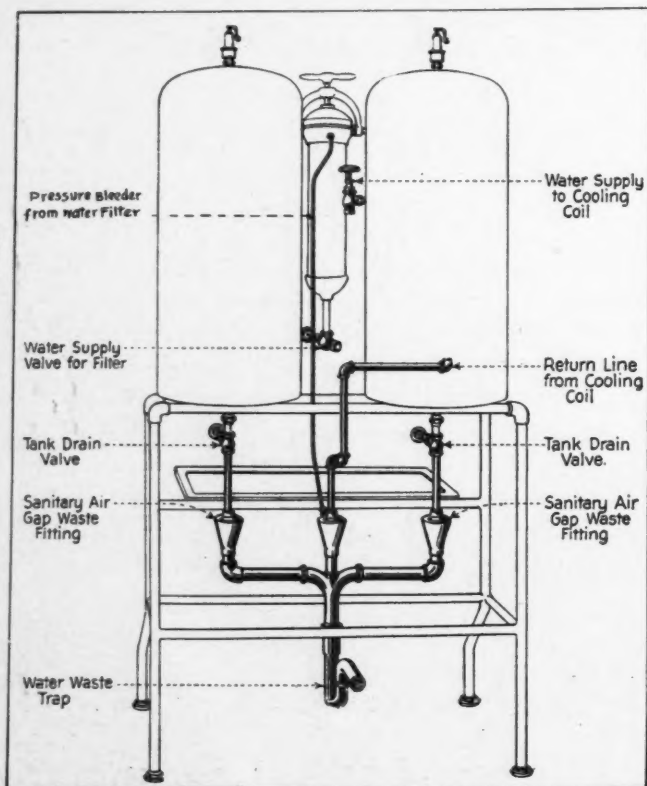


Fig. 2—(left) Water sterilizers showing air gap fittings on the water waste line and the bypass that will prevent water from seeping into the tanks. Fig. 3—(above) Illustration of good and bad instrument sterilizers.

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what different. In the period prior to 1928, it was common practice to have the waste from sterilizers piped through a closed system with sizes as small as a ½-inch pipe for an individual sterilizer and with a ¾-inch or 1-inch pipe for a battery of three or four units of sterilizers. Since that time, in many of the larger cities the plumbing code requires a minimum of 1½-inch pipe for a waste even from an individual sterilizer. For this reason, it is not an easy matter and probably in some cases impossible to

get a 1½-inch waste connection installed.

Under these circumstances it is almost mandatory that a 1½-inch line be run exposed through the rooms of the lower floors to the basement and the waste line drained over a sink or a floor drain. In that case it is usual to collect the wastes from the individual units and drain them into a funnel shaped receptacle with the opening from the end of the collecting pipe or pipes at least 2 inches above the top of the drain funnel.

Laundry Costs Vary Widely

THE total amount of hospital laundry expressed in terms of pounds per bed per month ranges from 42 to 533, according to figures compiled from a study made by The HOSPITAL YEARBOOK. This includes all the laundry done in the hospital such as that for patients, personnel and dining rooms. The hospital with only 42 pounds per bed per month is a large state sanitarium in Missouri, while the hospital using 533 pounds of laundry per bed per month is a large Philadelphia general hospital. Five of the hospitals reported from 200 to 300 pounds per bed per month; four reported from 100 to 200 pounds, and four, more than 300 pounds. Ten of the hospitals did not maintain laundries.

All hospitals reporting on the purchase of soap for the laundry stated they purchased ready-made brands although two manufacture part of the soap used. Branded soap is used by eight institutions while six use unbranded soap.

Starch consumption in hospitals runs from 10 to 300 pounds per month. Nearly all hospitals used an identified branded product. Stain remover seems to be purchased by most of the hospitals but the amounts used per month were expressed in quarts, pounds and dollars and could not be compared. The amount of detergent used ranged from 60 pounds to 4 barrels.

Practically all of the hospitals doing their own laundry use a large number of carts and trucks. Those giving a count on this item range from three to 120. Replacements on carts and trucks are made at various times, from three to twenty years, the most frequent figure apparently being about five years.

Of the nine hospitals with linen marking machines, three use the type requiring heat to set the ink and five use the unheated type. Several hospitals mentioned that a foot power linen marker was most suitable for institutional use.

Of seventeen hospitals reporting, seven have a water softener and ten do not. All those with the softener report satisfaction with its use. Five of the ten without softeners are now considering their purchase.

Laundry costs were reported by two hospitals sending the laundry out. Each of them pays four cents a pound although in one instance this does not apply to uniforms which are charged at thirty cents each. As compared with this, practically all the hospitals doing their own work had much lower costs. Seven of the eleven reporting figures have costs between one and two cents per pound. Two reported costs from two to three cents a pound; one reported five cents a pound, and one, five cents apiece.

When these figures are given in terms of costs per patient day there is a range from 1.3 cents in a large marine hospital where the average number of pieces per bed per month is only seventy-nine, to 39 cents in an outstanding New York general hospital. Too much accuracy should not be given to these figures, however, as in several instances it was apparent by inspection that errors had crept into the computation. Apparently even hospital administrators get mixed up in their decimal points.

The purchase of laundry supplies is handled by the administrator in eight of the seventeen hospitals reporting, by the laundry manager in two and by city, state or federal purchasing agents in six hospitals. One hospital passes this responsibility on to the executive housekeeper.

When it comes to laundry equipment the administrator decided in nine instances, city, state or federal authorities in five, the laundry manager in one and the housekeeper in one. Much the same condition applies to the decision as to the amount of supplies to buy except that here the laundry manager has a larger authority in four institutions.

Fourteen hospitals reported that they have set up weekly quotas for

various groups in the institution to control the amount of laundry used. Those reporting quotas stated that either three or four uniforms were allowed per nurse; from three to seven aprons (most of them allow either six or seven), one or two caps, four to seven bibs and three sets of cuffs were most frequently reported.

On the question of personal laundry for nurses the answers varied widely, twenty pieces per nurse per week being the figure most frequently mentioned. Fewer hospitals have set up quotas for patients although several stated that they allowed one change of bed linen per patient per day. In nurses' homes, hospitals seem to be about equally divided between those giving two sheets per bed per week and those giving one. Pillow slips were handled much the same as sheets. Eighteen hospitals reported on the question of checking laundry. Fourteen stated that they check laundry in and out while four do not. Nine check individual items and eight check by weight. Three of the hospitals do some items each way.

Several hospitals require that worn out pieces be passed on by someone in authority before they are changed.

Filtering Agar by Vacuum

By Marie X. Long

To filter agar by the vacuum method, make the filter from two thicknesses of cotton sandwiched between gauze and tied securely over a large mouthed bottle. Be sure the bottle is sufficiently large to hold all of the agar with room to spare, otherwise use two bottles and trim the edge of the filter to avoid waste.

When the agar-agar has been entirely dissolved in bouillon, put the filter covered bottle upside down in the medium and place it in a sterilizer or autoclave. Run up the sterilizer sufficiently to create a vacuum, so that the agar will be sucked up into the bottle. Be sure to remove it from sterilizer while it is hot, otherwise it will run back into container. Plain agar or glucose agar can be tubed at once, which is a marked advantage.

Aiding the Hospital Carpenter

In most maintenance problems labor is the biggest expense factor. Reducing man hours reduces cost. In line with this thought we installed a wood working machine in the carpenter shop. It cost \$350 and paid for itself in six months. It performs practically every type of operation encountered by the hospital carpenter in working with wood. Adjustments are made quickly and accurately. The result is a saving of time with an improvement in the work.—Walter Mezger, Knickerbocker Hospital, New York City.



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Wishing for the job that'd give you ownership of all your world; *dreaming* of a job that'd give you thrills; *planning* on the day you'd own a job that'd make you stride and smile and sing the songs at home, off time, they'd never let you sing at work.

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The delivery date to you *could be* fairly soon. The *price* is all you've got, and cheap at that.

For days that race, for a chin that tilts, for eyes that shine, for a throat that aches to hum and sing *give all you've got, give more* than they ask or want. Take the kind of a job you dream of owning (we'll find it for you) and then *live* with it, and *work* at it, love it and *lick* it 'til you stride and smile and sing the songs at home they'd never let you sing at work. That's the price you'd pay.

Life *can* be sweet, can be *sweeter*. Write and tell us what you want, who you are, what you've done, where, what you'd like to do. Let us find it for you.

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CHICAGO, ILLINOIS

HOUSEKEEPING

Housekeeping Humanized

By Doris L. Dungan

WE HAVE been careful with the valuable equipment necessary to run our hospitals but we have been careless to the point of exploitation where human "tools" were concerned. Human beings need as careful handling as machinery.

It is time to look around our attics and basements and see with just what kind of living conditions we expect our employees to be content. Could we eat the meals served to our employees or sleep in their beds?

Every employee has a right to a living wage, to a clean bed, good food and sanitary working conditions. More than that, he has a right to work under a trained executive who can instill in her subordinates feelings of respect, admiration and loyalty and a belief in her desire to be an understanding sympathetic leader in a common work.

Selection of employees for the housekeeping department is necessarily limited by the salary that can be paid. This department controls 25 per cent of the total employees but only 14 per cent of the total pay roll. There are three points of view about payment; usually one pays what other hospitals do for the same type of work, or one may pay a slightly higher rate to obtain greater interest or pay may be in relation to certain factors pertaining to the job.

Factors Determining Pay

In determining the rate of pay several factors must be considered. The two most important are the cost of living and the financial condition of the institution. Other factors cannot be determined in advance so that it is wiser to start a beginner at a lower rate and then increase him to the standard rate if his service is satisfactory. The amount and quality of work accomplished, regularity and punctuality, previous education and amount of instruction necessary, disagreeable nature or hazards of the work, the extent of demand for this type of work and the length of service and possibilities of advancement, all affect the rate of payment.

In hiring people the nature of the job should be explained. This includes the precise nature of the opera-

Improved living and working conditions for employees and sincerity and sympathy in dealing with them will create loyalty to your institution.

tion, the pay for beginners, scale of advances, time requirements, opportunities for promotion and any unattractive features of the work.

A personal interview not only serves to give information to the worker and obtain information from him but also helps to establish friendly relationships for the future.

Required Physical Qualifications

Physical qualifications that should be checked before hiring are age, marital status, number of dependents, walking ability and condition of shoes and feet, condition of hands (are all the fingers needed?), hearing, eyesight, height and weight. Height is especially desirable in a porter or window washer and weight may be a handicap both because of the working space and the extra amount of energy which a heavy person must use. Voice quality and skin conditions, neatness, deftness and personal cleanliness all must be considered.

Mental qualifications can be checked by the age at which the applicant finished school. A person who is too intelligent would not be happy in this kind of work. Because of the low wage scale, workers are usually below the average level of intelligence.

In scheduling the work, man the department with teachable and capable employees. The number depends on the type and policy of the hospital and its architectural arrangements. Schedules should contain the day-to-day work with number of rooms or floors to be done, routine and time, when possible. Exceptional work and heavy cleaning duties that do not occur daily should also be listed as well as the hours on duty. Sometimes

separate instruction sheets are necessary for one or two items on the schedule.

In training workers adequate instruction must be given in a manner suited to the individual. Instructions may be written or oral, given individually or in a group. Remember to go slowly and tell the worker that confusion is usual with beginners and not a reason for discouragement. Mistakes are indications that more help and instruction are necessary. Make the instructions as simple as possible and review them with the worker, explaining why things should be done that way. Form an opinion of the worker on the job. Rosenstein, in his "Psychology of Human Relations for Executives," gives the following complete study of the worker on the job:

(1) Is the employee liked by co-workers? (2) Does the employee mix with others? (3) Does he prefer working alone or in groups? (4) Does the employee need a good bit of supervision? (5) Does he catch on to new things quickly? (6) Is he a good influence in the group? (7) Does he like new jobs?

(8) Does he take criticism and correction in the right spirit? (9) Is he generally happy in the department? (10) Does he quarrel with others? (11) Does he lose his temper quickly? (12) If his feelings are hurt, does he recover quickly? (13) Does he spread gossip of malicious nature? (14) Is he friendly but respectful as a subordinate? (15) Is he considerate of feelings of others? (16) Is he careless or careful of personal appearance? (17) Does he talk too much? (18) Is he a pleasant and cheerful person? (19) Does he get on other people's nerves? (20) Is he selfish?

(21) If he were in charge of a group, would he obtain respect as a person or respect for position only? (22) Is he helpful and cooperative? (23) Does he admit and report mistakes frankly? (24) Is he careful or careless of materials and equipment? (25) Does he always try to keep busy or is he a time waster? (26) Does he carry outside activities into plant?

Common Needs and Desires

Certain fundamental needs are common to us all; most important is the need for security. The worker who is in constant fear of losing his job cannot do good work. We all have a desire for approval and recognition, a desire for response and affection, a desire for possession. This can be satisfied by giving workers their own tools, their own seats at table or their own lockers. There is a universal desire for beauty. Workers can be taught the beauty of cleanliness and orderliness.

The housekeeper must study to increase her ability to get on with people. The only way to get people to

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do things well is to arouse their interest. Arouse enthusiasm in your plans by letting others help. Show that you consider the other person important by noticing and remembering his wishes and preferences.

The greatest incentive of any worker continues to be three meals a day and a place to sleep. Other incentives we may use are the assurance of regular work and the careful selection of the worker to fit the job so that he will be happy because he is able to handle the work. Workers can be taught pleasure in work for its own sake and given a sense of value in its performance by teaching them the relationship and importance of their work to the hospital.

Transfer and promotion when advisable, shorter hours, suggestion systems, employees' meetings and promotion of fellowship in the department may all be used to advantage.

There are certain tools we use in dealing with employees to promote the response we wish. Enthusiasm is a stimulating tool. No one thinks more of your job than you do yourself so be enthusiastic about your work and you will carry your workers with you. Fatigue is the enemy of enthusiasm, a hot meal and a rest period in the middle of the day will help to guard against tiredness. Fatigue causes people to drop things, to fall, to be irritable and to be ill more often. Cheerfulness and a sense of humor are stimulating tools, as is also unselfishness. If you compliment an employee or pass on to your superiors the knowledge of any unusual ability it makes them feel you are generous and too big to steal the other fellow's credit.

Calls for Poise and Calmness

The stabilizing tools are calmness and consistency. If you are calm in the midst of excitement your poise tends to quiet people. Consistency or stability of personality gives people confidence in your decisions.

Receptiveness is a time-saving tool. If the worker is at ease with you he will immediately get down to business. If any employee in your department is afraid to face you with his problems, mistakes or grievances there is something wrong in your attitude. Simplicity is another time-saver. Simplicity in the way you give instructions saves many repetitions. Frankness saves time all around; say exactly what you mean and allow the other person to do the same. Impresiveness in the way you give instructions is time-saving. You must have a definite knowledge of the job to give oral instructions or demonstrations.

Conforming tools are tools that make people wish to cooperate with you or even to cooperate without

realizing it. Tact is important. This does not mean not being frank but knowing when to give in and when to take a stand. Don't meet every situation full force, learn when to let things roll off. Tolerance and patience help oil the wheels.

Restraining tools are dignity and courtesy. You cannot afford not to be courteous to your employees. No well trained person ever took advantage of courtesy but resentment against rudeness or abruptness will lead to department inefficiency.

Tools that fashion loyalty are friendliness and interest. No one is loyal to anything unless he is emotionally attached to it. Our problem is to identify our workers emotion-

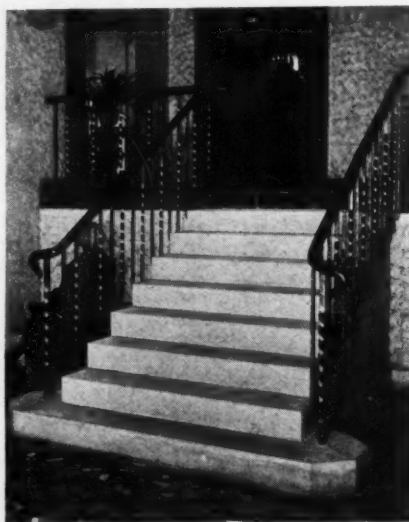
ally with our institutions so closely that a criticism of the institution becomes a personal criticism. Take the time personally to be interested in your workers' welfare and happiness, make opportunities for contacts of a friendly nature.

These tools can be bought only with absolute sincerity. No matter how far we progress with higher wages, shorter hours, rest periods or medical examinations, every worker still needs emotional meaning to his work to be happy. Perhaps our brains and sympathies can stretch to cover some of the places our budgets miss.*

*Read before the American Protestant Hospital Association, Atlantic City, September, 1937.

THE HOUSEKEEPER'S CORNER

- Badly stained marble may be cleaned with a paste made of two-thirds of a good detergent and one-third baking soda. Apply to the floor and leave overnight or from twenty-four to forty-eight hours. Rinse with clear water. Coffee stains may be removed from marble by covering the



Marble stairs require much care.

stain with a cloth saturated in a glycerine solution made of one part of glycerine to four parts of water. Javelle water also is effective. Iodin stains may be removed with alcohol. Other removers of iodine stains are ammonia water and a paste made of equal parts of borax and washing soda.

- Small pieces of material left over from upholstering may be used to make a new and different covering for a chair. Apply narrow strips of the material vertically to the outside of the chair, concealing the seams by using a piping in a darker color or a narrow cotton fringe. Material of

darker or contrasting color may be used for the cushion and the inside of the chair; a combination of three materials often is possible. This arrangement is particularly good for barrel chairs.

- A small amount of water wax added to the water when washing woodwork leaves it with a nice gloss, according to Bernice Stein, housekeeper at Presbyterian Hospital, Chicago.

• Mrs. Nettie I. Smith, housekeeper at Hamilton General Hospital, Hamilton, Ontario, is busily organizing a chapter of the NEHA, which will be the first one in Canada.

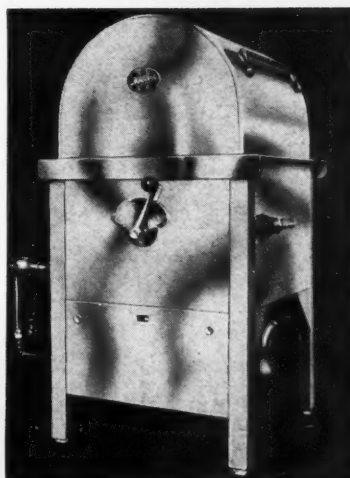
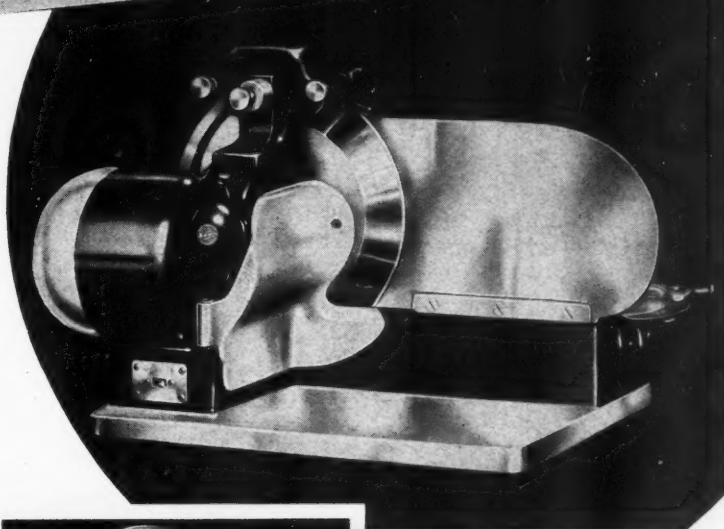
• Winners of a model room contest were announced at the October meeting of the Philadelphia branch of the National Executive Housekeepers Association. Mrs. Doris Dungan, housekeeper at West Jersey Homeopathic Hospital, Camden, N. J., received the award for the model private hospital room. Mrs. Kathryn Peileke, housekeeper at the University Hospitals, Philadelphia, won the prize for the best model nurses' living room. Other winners were Eleanor King, Mary Sellers and C. Muriel White, whose exhibits were a model dining room, living room and bathroom, in that order.

• In training new maids, Miss Stein, the housekeeper at Chicago's Presbyterian, first discusses with them the policies of the hospital and their particular duties. They are next given a card which specifies where they are to be and what they are to do during the morning and the afternoon. Duties are so arranged that a worker who is to scrub floors during the morning, for example, will be given less arduous work in the afternoon. This plan gives variety and makes the routine less monotonous.

New Hobart Model 411 THE FINEST KITCHEN SLICER

*Again...Hobart
Gives More for the Dollar*

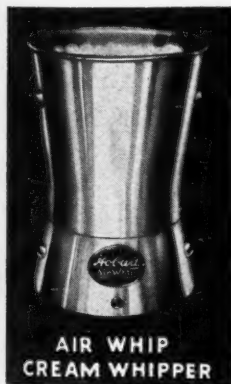
THINK OF ALL the desirable features of an IDEAL Kitchen Slicer—SEE them in this new Hobart Model 411! Outstanding is the exclusive Hobart ADJUSTABLE PRESSURE, AUTOMATIC FEED—quickly set for slicing foods ranging from soft, ripe tomatoes to hard, dried beef . . . The Hobart STAYSHARP Stainless Steel Knife . . . Kitchen-type FEED TROUGH that permits slicing all kitchen products . . . SLICE REGULATOR with 70 indications—thicknesses from 100 slices to the inch up to $\frac{3}{4}$ -inch slices—giving uniform servings at known cost. Many other features, each important. Sanitary—quickly cleaned. The EASE and convenience of its operation assure the widest possible USE of this slicer . . . and thus assure YOU the maximum savings (in time, labor and food) that can be effected with an electric kitchen slicer.



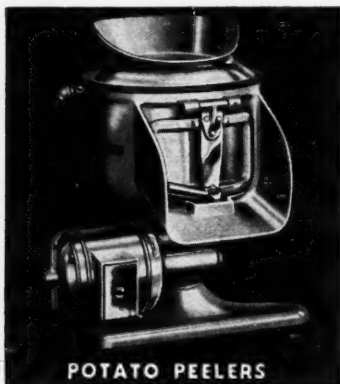
NEW MODEL "LM" Hobart Dishwasher (left), a COMPACT heavy-duty machine; with full-size dishwashing and rinsing capacity. A great achievement in performance, and in PRICE.

KitchenAid

TWICE AS EASY TO OWN! Sensational new Model "K" KitchenAid Electrical Food Preparer for your home "does it all," at an exciting price. See cut below.



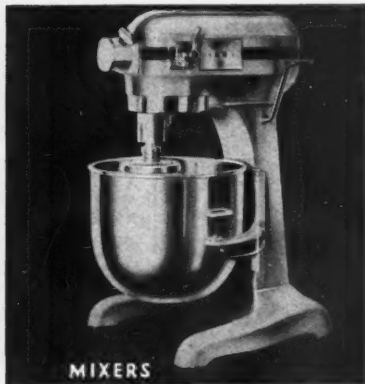
AIR WHIP
CREAM WHIPPER



POTATO PEELERS



FOOD CUTTERS



MIXERS

HOBART Electric Kitchen Machines



THE HOBART MFG. CO., 911 Penn Ave., Troy, Ohio.

- ☐ More information, please, on new Model 411 Kitchen Slicer.
☐ "LM" Dishwasher ☐ Larger Dishwashers ☐ Mixers
☐ Potato Peelers ☐ Food Cutters ☐ Air Whips
☐ KitchenAid for the Home

Name.....

Address.....

City and State.....



Color for Rooms

By Mrs. A. B. Tipping

SELECTION, painting and care of furniture in a modern hospital are never ceasing problems—particularly the selection and color schemes. With improvements taking place almost monthly in types of beds, tables, lamps and mattresses, it is necessary to buy with considerable forethought if the hospital is to remain up to the minute in patient comfort. There appears to be no solution other than to purchase new supplies in small quantities only.

At present there is a trend toward making hospital rooms as homelike as possible, partly by furnishing them with wooden furniture in place of the old-style steel and iron. Touro Infirmary, New Orleans, has experimented in this respect and results have been satisfactory.

More important by far in "home atmospherizing" hospitals, however, has been the tendency to break away from former drab color schemes for both furniture and rooms. The gloomy pall of hospitals is definitely a thing of the past. There must be cheerfulness and beauty.

In past years practically all the dark furniture in our hospital has been repainted in pastel colors. In addition, walls and draperies are in colors to blend harmoniously, special care being taken to provide attractive draperies.

Until recently green, oyster white and ivory predominated but lately we have experimented with other colors and the innovations have been even



Walls in soft colors and furniture and drapes to contrast achieve atmosphere in the sun parlor (above) and in the private rooms.

more attractive. In our experience the two best new color schemes have been light blue walls with ivory furniture and white draperies and pinkish-gray walls with gray furniture and gay salmon draperies.

Proper care of the furniture is a major problem, owing mainly to the large amount of drugs, acids and water so freely used. Added to that is the fact that every room's contents must be thoroughly washed with soap and water each time it is vacated, and soap does paint no little harm.

To combat this, a coat of good liquid wax is used as a preservative, and glass tops are placed on bureaus and tables. These glass coverings present a serious breakage problem, yet they are essential if tables are to retain their new appearance.

Reclining chairs are covered with well made washable slip covers in colors to match the rooms, adding to the cheerfulness. Continual inspection

by housekeepers and supervisors maintains the furniture in top condition. These persons must immediately report any damage by duplicate requisition to the maintenance department. There the articles are repaired or painted as the need may be.

Most of our sad experiences in materials have been due to faulty choice of mattresses and rubber sheeting. In the purchasing of mattresses great care should be exercised in choosing a reputable firm from which to buy, particularly if the articles are to be inexpensive. Mattresses should be well constructed of good, clean layer cotton. If innersprings are used it is important to have springs well padded with cotton felt. High-grade ticking

is essential, while muslin covers greatly prolong the life and appearance of the mattresses. The standards for mattresses published in The HOSPITAL YEARBOOK are helpful in their selection.

Naturally, no hospital bed is complete without a rubber sheet. It is poor economy to buy other than the best rubber the market provides for replacement orders will shortly erase any original imagined savings if inferior quality is purchased. At times in the past our institution has attempted to save by buying inferior rubber sheeting. The results were that many sheets had to be discarded within six months and several mattresses were ruined. Top quality sheeting bought fifteen years ago is still in constant use in many of our rooms.

Although high quality furniture is a definite asset, the main problem is to create a cheerful, attractive color scheme to set off the furniture.

CITRUS JUICES that *Sing a Song* OF CALIFORNIA *SUNSHINE -*



-and make better drinks
QUICKER—EASIER

Nothing is more beautiful than a well kept citrus grove, and nothing more delicious and inviting than choice citrus fruits picked at the moment of ripeness and *used at once*. Trujuis is the 100% juice of selected oranges, lemons and grapefruit, tree-ripened and matured in Southern California sunshine. Quick frozen and vacuum packed at the peak of the season, Trujuis always has the same quality and flavor as freshly picked fruit *used at once*. There are only two ways to get this quality and flavor—at the grove, or with Trujuis. Quick freezing preserves all values: flavor, color, body, sweetness, aroma and vitamins. Trujuis is uniform, in or out of citrus seasons. It is always ready—always rich in the exotic qualities that only Southern California sunshine can ripen. 100% orange, lemon or grapefruit juices—delivered frozen, in enameled cans.

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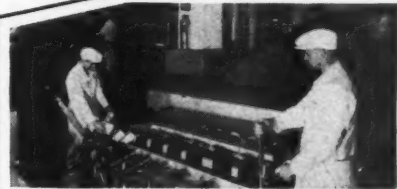
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MAINTAINS FULL
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Trujuis is received in acid proof tanks at the beginning of the canning line.



Frozen quickly to solid condition, Trujuis is removed from the freezing tubes.



Zero temperature stops all change in quality while Trujuis is in stock.

FOOD SERVICE

Conducted by Anna E. Boller, Rush Medical College

Second to None

By P. Mabel Nelson

DIETETICS, the science of feeding people, is a relatively new field. Its development as a profession has been due largely to the efforts of the women who, sensing the opportunity for service and the greater power that organized effort would give them, banded together in 1917 to form the American Dietetic Association. Previous to that time, it had functioned as a subsection of the American Home Economics Association, an organization only nine years its senior.

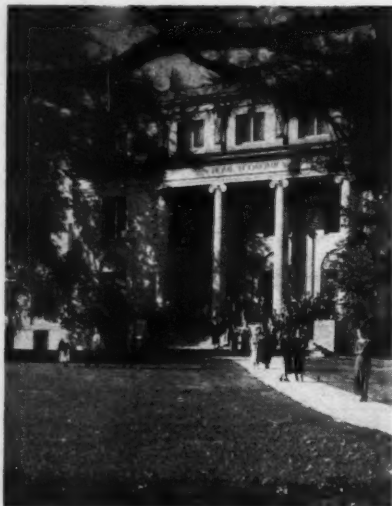
At once the association attacked its problems, one of which was the lack of uniformity in the training of its members. The members were faced with another serious problem, that of the young women who desired to follow in their footsteps professionally. These students were from home economics schools but without formal dietetic training. They had, however, excellent background in general home economics and a bent for scientific

This is the ranking given the dietetic profession by Dr. P. Mabel Nelson, who is training college women for this field.

formal hospital training to continue and enlarge their scholastic preparation; there was no standard length of time for securing their apprentice training.

Great strides have been made in changing that situation to the one that is in vogue today. There is now a definite minimum standard of course work which has been approved by the dietitians and which must be met by the students who desire to spend a postgraduate year in the hospital under the guidance of the head dietitian and her staff. These "minimum essentials" in course work represent the recommendations of a joint committee composed of dietitians and heads of departments in home economics offering undergraduate curriculums in dietetics.

It was understood that these rec-



Future dietitians strolling on the campus at Iowa State.

work. These students were handled more or less as individual problems by deans or heads of home economics departments, were apprenticed by them to successful dietitians and thus received practical experience following two, three or four years of college work. There was no organized undergraduate course of study; there was no

commendations were not to be used in an iron-clad manner in determining the worthiness of an applicant for training but to serve as a basis for judging the adequacy of the candidate's preparation. It is entirely conceivable that one candidate may have had more work in some phase of the requirements suggested than in another and be equally desirable or perhaps preferable to the student who meets the standards, credit by credit. The dietitian should use her best judgment in evaluating the qualifications of each applicant.

Personality traits, the ability to work with associates, to go ahead independently, to use judgment in an emergency, are, or may be, more than the equivalent of another course. Radiant, buoyant health, a body well-groomed and in good physical condition, no bad teeth, tonsils, arches or backs are essential also. One must be an example of good nutrition to reassure patients that the food principles advocated will help them. Underweight or overweight girls are therefore discouraged until they demonstrate that they can control their own physical handicaps.

When the dietetic curriculum at Iowa State College was formulated, it was borne in mind that the dietitian must be trained for future homemaking responsibilities as well as for an immediate professional situation. Great specialization in subject matter was avoided.

May Choose From Many Subjects

The courses prescribed in the freshman year are common to all curriculums of the home economics division. The subjects studied are elementary design; English composition; history, in which is given a historical survey of the economic, political and social institutions of Western civilization; general chemistry; general physics; household equipment; general textiles; general biology; health education, and physical education. Each student must elect a specific curriculum at the end of the freshman year. In order to help her, there is given throughout the year by the heads of the respective departments a series of lectures presenting the qualifications needed for successful pursuit of each curriculum. Individual conferences follow these lectures if and when requested.

In the sophomore year, the studies are food preparation; human physiology; organic, food and physiological chemistry; principles of economics, with emphasis on consumption and consumer problems; costume design; house planning, and interior house design. Beginning work in technical journalism is optional.

The course work of the junior year is more specialized. Large quantity cookery, with experience in the preparation and service of lunches; meal



Weighing foods for trays to meet individual dietary needs.

FOR THE DIABETIC DIET . . . Tomato Cheese Salad. Fill a large mold $\frac{1}{3}$ full of aspic made with Libby's Tomato Juice. Chill. Soak 1 tsp. gelatin in 2 tbsps. cold water and dissolve over boiling water. Add to $\frac{1}{4}$ c. mayonnaise well-mixed with $\frac{1}{4}$ c. cottage cheese. Add this to the firm layer of tomato aspic in the mold. Chill. When hard, cover with another layer of aspic and chill.



Libby's gentle press TOMATO JUICE

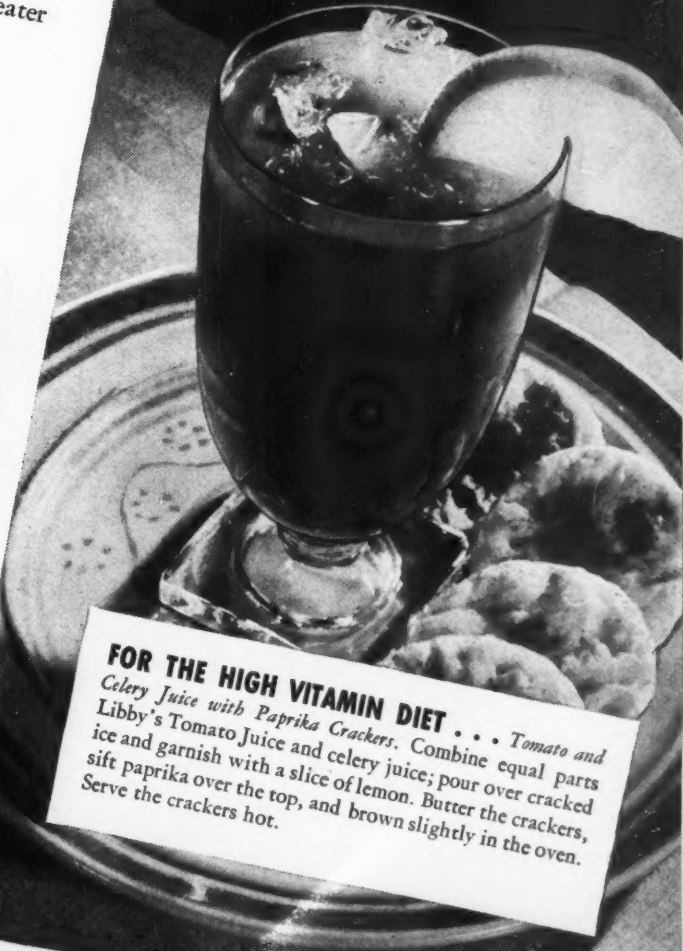
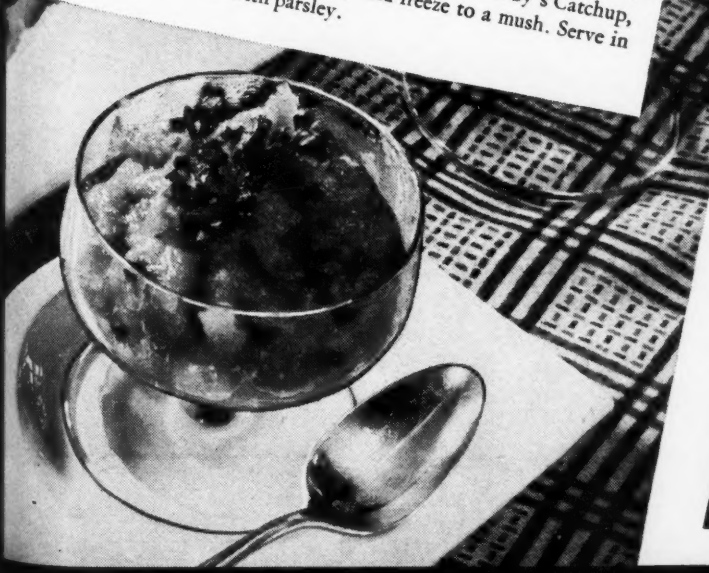


RICH IN VITAMIN C . . . finer flavor, too!

● Possibly you've been thinking that all tomato juices were alike in the matter of vitamin content. But the truth is they vary in nutritive value just as they do in taste. ● Libby's Tomato Juice is made from unblemished, perfectly-ripened fruit quickly packed by a special process that guards against oxidation. It contains Vitamins A, B, C and G; is a dependably excellent source of Vitamin C. ● Libby's patented gentle press method produces a juice with noticeably finer flavor and color. Patients and staff will appreciate its greater goodness, whether you're serving it "straight" or in made dishes.

● Libby's 100 Fine Foods include Fruits and Fruit Juices, Vegetables, Pickles, Condiments, Canned Meats, Evaporated Milk, Alaska Salmon. Each comes in regular and special sizes for institutions. In addition, Libby packs Homogenized Foods for Babies.

FOR THE REDUCTION DIET . . . Tomato Frappé. Soak 1 tsp. gelatin in a little cold water. Heat 2 c. Libby's Tomato Juice, and dissolve gelatin in it. Cool; add 1 tbsp. lemon juice, 1 tbsp. Libby's Catchup, and seasoning to taste. Turn into tray and freeze to a mush. Serve in chilled cups and garnish with parsley.



FOR THE HIGH VITAMIN DIET . . . Tomato and Celery Juice with Paprika Crackers. Combine equal parts Libby's Tomato Juice and celery juice; pour over cracked ice and garnish with a slice of lemon. Butter the crackers, sift paprika over the top, and brown slightly in the oven. Serve the crackers hot.



Photographs by John W. Barry, Cedar Rapids, Iowa.

planning for family and other units; nutrition and dietetics; household bacteriology; principles of sociology; American government; accounting, with emphasis on hospital situations; general psychology and child psychology, and problems of personal clothing construction are studied. There is opportunity at this stage for the selection of elective courses that will round out the student's training in the phases of the work that interest her most.

The senior studies experimental cookery; art appreciation; child care and training; child physiology; food purchasing, with emphasis upon the problems of buying for institutions; textile economics, with emphasis on purchase of textiles; institution administration, where problems encountered in managing a food unit are discussed; home management lectures and residence in the house, where a baby under two years of age is a member of the group; diet in disease; nutrition of children; a seminar in nutrition and dietetics, which has for its purpose acquainting the student with one of the major problems she will face when she leaves college—that of keeping abreast of the times in pertinent subject matter, and a course in methods for dietitians in which she is given help and guidance in the problems that she will encounter when teaching student nurses and dietitians, interns and patients in the hospital.

The elective credits total fifteen quarter-hours. These may be taken in the institution management field; in household equipment, which will enable her to enter the field of home demonstration work, or in journalism. Instead of pursuing one additional field intensively, she may elect one or more courses in several subjects, such as ceramics, home floriculture, farm meats, Shakespearean drama or religious education. It is possible, if she elects courses wisely, to complete enough work to qualify her for a job in a second field.

The training of students who transfer credits to Iowa State College to complete dietetic work is a challenge to the foods and nutrition department. Out of a total of thirty-five dietetic students who received the B.S. degree in home economics, 1936-37, twenty-four, or more than two-thirds, were transferred after two or three years of work elsewhere. It is evident then that the specialized course work of

An attractive tray (top) is a fine way to arouse the appetite. The weight of the roast (center) is noted before cooking so that shrinkage may be estimated. Each vegetable is carefully prepared to preserve its flavor and color (below).

CANNED FOODS IN THE CONTROL OF LATENT AVITAMINOSIS C

• The identification of cevitamic acid (1-ascorbic acid) as vitamin C served as a direct stimulus for the intensive study of the multiple problems involved in determining the human requirement for this factor. As a result of much extensive work, there have been developed three methods for estimating the intake or store of vitamin C in the body.

The "retention or saturation" test is carried out by administering a massive dose of vitamin C and determining the amount excreted in the urine in a given time (1).

As a second method, the daily excretion of vitamin C in the urine is considered indicative of adequacy of the intake (2).

A third method is the determination of the amount of vitamin C in the blood plasma or serum (3).

These tests have been combined in balance studies and may serve as valuable checks in the diagnosis of latent scurvy, when used

separately or in conjunction with the less specific capillary resistance test (4).

Evidence is accumulating from the application of these tests which confirms the older view that acute cases of scurvy are rare in this country. However, this evidence does indicate rather wide occurrence of the sub-clinical forms of scurvy (5).

Correction of this condition is largely a matter of modification of the diet to include more liberal quantities of the fruits and vegetables which are known to be good sources of vitamin C. Recent reports indicate that vitamin C in such fruits and vegetables is afforded a good degree of protection during modern canning operations (6).

Since they are available at all seasons on practically every American market, these canned foods afford a valuable and economical means of controlling latent avitaminosis C.

AMERICAN CAN COMPANY

230 Park Avenue, New York City

(1) 1935. The Lancet 228-I, 71

(2) 1936. Am. J. Med. Sci., 191, 319

(3) 1935. Proc. Soc. Exper. Biol. & Med., 32, 1930

(4) 1933. J. Lab. & Clin. Med. 18, 484

(5) 1937. The Avitaminoses

Eddy and Dahldorff

William and Wilkins

Baltimore

(6) 1936. J. Nutr. 12, 405

1936. Ibid. 11, 383

1935. Am. J. Pub. Health 25, 1340

This is the thirtieth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.



The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

the curriculum must be taught in the senior college. In two years or less they must acquire the fundamentals for a highly specialized professional career.

There is undoubtedly an increasing interest in the dietetic field, perhaps

The economic situation governs more or less directly the interval that elapses before marriage. In good times, marriages occur directly after the fiancé becomes established. In times of economic pressure, girls work for several years before they marry



A student assistant checks the tray before it goes to the patient.

because it offers a challenge to the girl who is ambitious, who likes to manage people and situations, and who wants a professional field that offers certain satisfactions not to be derived from working with inanimate things. Many girls think they would not care for the routine of school teaching, yet they enjoy the teaching that must be done in the dietetic field. Another reason for the increasing interest may be that it offers excellent preparation for the profession of homemaking which, in most instances eventually becomes the life work of the students.

Dietetics has become so popular in recent years that many administrators are greatly concerned because of the number of women being trained. A survey made in November, 1936, of the location of the 196 girls who were graduated from the foods and nutrition department for the five-year period 1930-35, 168 of whom completed the dietetic curriculum, revealed that they were occupied as follows: 67 were employed as dietitians, 27 were taking a postgraduate year of training in hospitals, 15 were engaged in teaching, 15 were employed in the business field, 9 were at home by choice, 9 were with social service organizations, 5 were doing graduate work, 4 were employed in nonhospital institutional jobs, 3 were employed in extension service and 42 had left professional work for homemaking.

and may continue doing so for several years afterward. The general tendency, however, is for marriage to remove enough of them from the professional field to leave room for those coming on. If this situation continues, professional opportunities will not become saturated for some time. In the meantime, the dietetic job offers the alert, vigorous, well-trained woman a job replete with satisfactions, financial remuneration adequate for a decent living, and a challenge for service second to none.

Guide for Coffee Buyers

PPRICE nearly always determines quality, but quality and price are not always synonymous when it comes to coffee. Thus the primary rule for coffee buyers is to know what is wanted and what may be expected for the money. If the buyer can rely on the honesty of his source of supply, the task is easier.

As a preliminary to requesting bids for coffee from merchants, the wise coffee buyer makes sure of the blend of coffee wanted, as for example, 30, 40 or 50 per cent mild, this to depend on the price. Next to be considered are the grind, roast and package wanted, since coffee may be packed in amounts just enough for one service or making. It is unwise to buy more than a week's supply at a time.

The standard for judging is coffee from the famed Santos district in Brazil, the various grades being Santos 1 and 2, of which there is relatively little, Santos 3 and 4, which are standard, and additional grades up to 8, which is practically trash. It is further divided into three chief kinds, Santos, Bourbon Santos and Rio, a cheap, bitter and acrid-tasting coffee. Colombian coffee also is of three types, Bucaramango, Bogotá and Medellín.

It is the blending that gives coffee a particular type and flavor and most of the coffee on the market is blended. The base usually is Santos, with the mild coffees of Colombia, Venezuela and Mexico added in varying amounts to give body, aroma and resistance to heat. Blends vary greatly and may contain from 5 to 60 per cent of mild coffees with the balance Santos or Bourbon Santos.

Quite as important as the proper blending is the proper roasting, in the opinion of coffee experts. Flavor is determined by the degree of roasting. In this country a medium roast is preferred. Both flavor and strength may be affected by the grind. The buyer may choose from coarse, steel cut, medium, medium fine, fine and pulverized, bearing in mind that the type of coffee-making device to be used determines the grind.

When brewing the coffee, best results are obtained if the coffee-making device is kept scrupulously clean and the coffee is carefully weighed and measured. The water should reach the boiling point before it is poured over the dry coffee. After all the water has run through the coffee, repour at least once to obtain the desired strength and color. Flavor is improved if the coffee is allowed to stand for five minutes before serving. It should not stand much longer than this, so do not make it until shortly before time for it to be served. If cream is to be used with the coffee the cream should be warmed to room temperature.

Do not allow the coffee to stand in an urn longer than from one to one and one-half hours. The coffee will become black if the water in the jacket around the urn is allowed to boil after the coffee is made.

Suggested proper proportions and granulations are: (1) for an urn, 1 pound of fine grind to 2 gallons of water, (2) for a tricolator, 1 pound of medium fine grind to 2 gallons of water, (3) for a dripolator, 1 pound of medium fine grind to 2 gallons of water, and (4) for silex, 3½ ounces of pulverized to 12 cups of water. It is well to remember that the greater amount of coffee being made the less coffee will be needed in proportion to each gallon of water.*

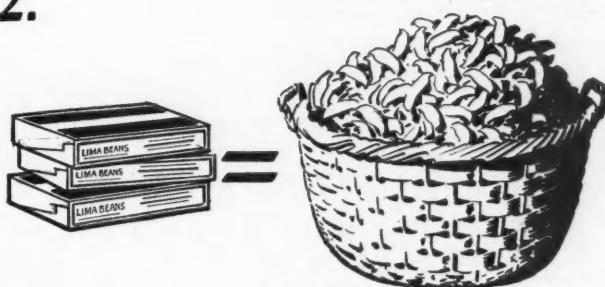
*Adapted from a paper given at the annual meeting of the Florida State Dietetic Association, St. Petersburg, 1937.

1.



GREEN LIMA BEANS . . . the famous Henderson bush variety. Limas that are sweeter, tenderer, packed full of richer flavor sealed in by quick-freezing machines *right at the farm!*

2.



EASY TO HANDLE . . . Packed in 40 oz. cartons for easy storage. Only 3 cartons of Birds Eye Limas are the equivalent of a full bushel basket of ordinary unshelled limas.

3.



NO PREPARATION! . . . Birds Eye Baby Limas come shelled—cleaned and graded. No kitchen fuss. No labor lost. And no wasteful pods to pay for. In Birds Eye you pay for the *beans*—not the pods.

4.



PORTION COSTS FIXED IN ADVANCE! Each 40 oz. carton of Birds Eye Limas gives you 20 to 24 servings. You can figure to the penny how much each serving will cost—how much profit each plate will bring. And no waste or spoilage to allow for!

5.



FARM-FRESH. Flavor *sealed in* by miracle quick-freezing machines *located right at the farm!* You serve them farm-fresh out of season as well as in. In fact, farm-fresher than the kind you ordinarily find at the height of the lima bean season.

6.



THAT'S THE MIRACLE of the patented process of quick-freezing used for more than two dozen kinds of Birds Eye Fruits and Vegetables.

For the highest quality
insist upon the *original*
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REG. U. S. PAT. OFF.

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Corp., 250 Park Ave., New
York City.

Private Room Tray



By Mary K. Sorenson, chief dietitian,
of Illinois Central Hospital, Chicago.

Spiced Strawberry-Beet Salad



Spiced beets
Lettuce

Hard cooked eggs
Cream cheese

Slice young spiced beets and arrange on leaves of lettuce alternately with slices of hard cooked eggs. Use two small whole beets to garnish salad and insert a small piece of green pepper in the top of each to represent stems. A little rosette of cream cheese can be piped on the lettuce to hold the two small beets in place as well as in an upright position. Serve with French dressing. This is a tasty, colorful combination and also is inexpensive and easy to make.—*Arnold Shircliffe*.

FOOD FOR THOUGHT

• A survey of the food habits of 1,000 New Yorkers has shown fairly conclusively that they are not consuming enough protein foods. Dr. Benjamin I. Ashe and Dr. Hermon O. Mosenthal have been studying normal, and apparently healthy, persons who have reported for health examinations over a period of years, and have come to the conclusion that the general health would be improved, both mentally and physically, if more protein were consumed in the daily diet.

Nutrition authorities have stated that the suitable daily protein intake ranges from 75 to 100 grams. The so-called minimal intake is set at 45 grams. Doctors Ashe and Mosenthal found that more than 60 per cent of the individuals examined were consuming only 42 grams or less of protein per day, and that out of the group of 1,000, only 40 ate 75 grams or more. Women were the chief offenders in the matter of low protein intake, and low blood pressure was found frequently in this group.

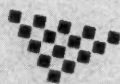
Many of these individuals were underweight, and a mild secondary anemia was common. Various workers have ascribed "nutritional" edema, fatigue, lack of resistance to infection and pellagra as being results of a low protein ration, also. Physicians did not find that persons who ate more than the recommended amount of protein suffered from high blood pressure.

• Prof. G. H. Whipple, University of Rochester, recently gave an interesting paper in which he explained the breaking down and manufacture of red blood cells. When they wear out the cells break down into three kinds of "scrap," according to Professor Whipple: iron, a pigment known as hemin, and a protein molecule called globin.

With a nice eye to values, the body carefully salvages the iron for future use. The hemin is discarded, and the big protein blocks of globin are probably used again in the building of new hemoglobin for the new blood. The manufacturing of the new red blood cells is carried on in the liver and the red marrow of the bones. Professor Whipple carries his theory further by explaining that the liver produces the building blocks, and the bone marrow acts as the "assembly line" from which roll the completed red cells packed with hemoglobin.

Professor Whipple has found that liver, kidney, pancreas and stomach (or tripe) are the most satisfactory foods for building new blood, with green vegetables and some fruits occupying an intermediate position. Grains and dairy products are lacking in the factors that build new hemoglobin in anemia.

LOW CALORIE DIET



Doctors praise this **NEW REDUCING DIET**

Every mail brings enthusiastic letters and requests from doctors for copies of this simplified Low Calorie Diet. And no wonder! With this Diet, your patient can choose her own menus—eat the foods she likes and lose about $\frac{1}{4}$ pound a day safely and sanely.

Clearly and simply, the Diet states just what foods and what quantity your patient should eat at each meal. And you'll be amazed, we think, to see what variety it offers. That is one secret of its success. Another is the Ry-Krisp—low in calories, high in appetite appeal—which encourages closer adherence to the diet because it tastes so good.

Each copy provides space for patient's name, date, the physician's personal instructions and signature and chart for recording weight lost. We will gladly send you copies of Ry-Krisp Low Calorie Diet and sample of Ry-Krisp. Simply use the coupon.

RY-KRISP. *Whole Rye Wafers*

RALSTON PURINA COMPANY, Dept. MH, 2260 Checkerboard Square, St. Louis, Missouri
Without obligation, please send me sample of Ry-Krisp
and copies of the Ry-Krisp Low Calorie Diet.

Name _____ Address _____
City _____ State _____

(This offer limited to residents of the United States and Canada)



December Dinner Menus for the Small Hospital

By Leta Linch

Dietitian, Lincoln General Hospital, Lincoln, Neb.

Day	Appetizer	Meat or Substitute	Potatoes or Substitute	Vegetable	Salad or Relish	Dessert
1.		Veal Steak	Boiled Potatoes	Creamed Peas	Green Olives	Apricot Wedge With Whipped Cream
2.		Hamburger	Baked Potatoes	Curried Succotash	Curled Celery	Grape Bavarian
3.		Fillet of Haddock, Tartare Sauce	Parsley Buttered Potatoes	Buttered Green Beans		Sprutter, De Luxe Plums
4.		Baked Ham, Raisin Sauce	Orange Sweet Potatoes	Coleslaw		Date Filled Cookies, Royal Anne Cherries
5.	Fruit Cup	Baked Chicken	Mashed Potatoes	Creamed Cauliflower		Chocolate Angel Cake, Lemon Sherbet
6.		Swiss Steak	Mashed Potatoes	Creamed Hominy	Pascal Celery	Date Pudding
7.		Meat Loaf	Pittsburgh Potatoes	Baked Squash		Oatmeal Cookies, Pears
8.		Liver and Bacon	Boiled Potatoes		Carrot and Apple Salad	Cottage Pudding, Vanilla Sauce
9.		Pot Roast of Beef	Franconia Potatoes	Buttered Beets		Pineapple Delicious
10.		Salmon Loaf With Sliced Lemon	Parsley Buttered Potatoes	Creamed Wax Beans		Frozen Blueberry Cobbler
11.		Veal Rosettes	Boiled Potatoes	Creamed Corn	Ripe Olives	Hermits, Fruit Cup
12.		Baked Chicken, Oyster Dressing	Mashed Potatoes		Cranberry and Apple Salad	Sponge Cake, Butterscotch Sundae
13.		Ham Loaf	Sweet Potatoes	Spinach With Egg	Spiced Pineapple Ring	Crumb Cookies, Black Cherries
14.		Roast Lamb, Mint Jelly	Mashed Potatoes	Creamed Celery		Peach Shortcake
15.		Veal Steak	Creamed Potato Cubes		Apple, Date and Celery Salad	Coconut Cake, Layer Ice Cream
16.		Roast Beef	Franconia Potatoes	Hot Cabbage Slaw		Orange Tapioca
17.		Escalloped Oysters		Creamed Peas	Molded Cranberry Salad	Cornflake Macaroons, Pears
18.		Spanish Steak	Boiled Rice	Creamed Brussels Sprouts		Prune Whip, Custard Sauce
19.		Stewed Chicken With Noodles	Parsley Buttered Potatoes		Head Lettuce, Thousand Island Dressing	Angel Cake, Cranberry Sherbet
20.		Veal Fricassee	Boiled Potatoes	Harvard Beets		Grapenut Pudding
21.		Porcupine Balls	Mashed Potatoes	Creamed Wax Beans	Green Olives	Fruit Cake, Bell Center Ice Cream
22.		Roast Pork	Riced Potatoes	Buttered Asparagus		Christmas Tea Cake, Cinnamon Apple
23.		Savory Meat Loaf		Spaghetti, Tomato Sauce	Head Lettuce, French Dressing	Fig Pudding
24.		Baked Fish	Parsley Buttered Potatoes	Buttered Green Beans	Peach Pickle	Strawberries, Christmas Cookies
25.	Cranberry Cocktail	Roast Turkey, Sage Dressing	Mashed Potatoes	Creamed Peas	Christmas Salad	Star Cookies, Santa Claus Mold
26.		Pot Roast of Beef	Franconia Potatoes		Club Vegetable Salad	Bakeless Fruit Cake
27.		Hamburger Balls	Escalloped Potatoes	Buttered Corn	Apricot Pickle	Sprutter, Fruit Cup
28.		Veal Birds	Riced Potatoes	Creamed Cauliflower	Watermelon Pickle	White Tea Cake, Strawberries
29.		Liver and Bacon	Mashed Potatoes		Waldorf Salad	Baked Prune Pudding
30.		Baked Ham, Frozen Horseradish Sauce	Creamed Potatoes	Buttered Asparagus		Orange Shortcake
31.		Escalloped Salmon	Parsley Buttered Potatoes		Cabbage and Tokay Grape Salad	Press Cookies, Peach Sauce

Recipes will be supplied on request by Anna E. Boller, The MODERN HOSPITAL, Chicago.

HIGH-CALORIC DIET

Indispensable to Convalescents

INFECTIONOUS FEVERS deplete vitality. It is an exhaustion comparable to fasting. Convalescents show a low metabolism for several weeks following the disappearance of the fever. The low metabolism is the consequence of generalized cellular damages.

When the infection clears, activity is curbed and rest periods instituted. The patient is ready to gain. The problem is to bring about sufficient intake of food. The initial diet consists of small portions of each food prescribed and the amounts are gradually increased.

The high caloric diet is indispensable. It is made possible by reinforcing foods and fluids with Karo. Every article of the diet can be enriched with calories. A tablespoon of Karo provides 60 calories.

Karo is relished added to milk, fruit and fruit juices, vegetables and vegetable waters, cereals, breads and desserts. Karo consists of dextrins, maltose and dextrose (with a small percentage of sucrose added for flavor), not readily fermentable, rapidly absorbed and effectively utilized.

For further information, write CORN PRODUCTS SALES COMPANY, 17 Battery Place, New York, N. Y.



★ Infant feeding practice is primarily the concern of the physician, therefore, Karo for infant feeding is advertised to the Medical Profession exclusively.

NEWS IN REVIEW

Arbitration Board Gives Seattle Hospitals Fair Deal in Settling Labor Controversy

Seattle, hotbed of labor strife, last month concluded a hospital labor controversy to the satisfaction of both the hospitals and the labor interests involved.

Settlement was effected through an arbitration board comprised of Mayor John F. Dore, representing the union; Dr. C. W. Sharples, superintendent of the Seattle General Hospital, representing the hospitals, and C. H. Howell, a bank manager, selected by the two as the third member of the board.

Eight months ago when the hospital labor controversy originated in Seattle, the Union of Building Service Employees asked for recognition and for increased wages of janitors and other nonprofessional hospital employees through the Seattle Hospital Council, an unofficial body representing all of the city's hospitals. About three months ago the request was passed on to a board of arbitration, since the council did not have the power to act on behalf of the hospitals.

The arbitration board granted substantial increases to most workers employed by the hospitals who are affiliated with the Building Service Employees International Union. Simultaneously the hospitals announced similar wage increases for nurses, office help and laboratory workers not affiliated with the union. Nurses will receive \$75 a month, plus maintenance.

"The hospitals are well satisfied with the results and commend the fairness of the arbitrators," Doctor Sharples said. "We felt that if janitors and other manual workers were to be raised, we would have to grant similar raises to professional workers. The nurses will get an increase of about \$10 a month. It is not enough for them but we hope to grant them additional increases under the new rates now in effect."

The board's award fixes specifically the monthly minimum basic wage of janitors at \$100, an increase of about \$23; elevator operators, \$85, an increase of \$13; nonsurgical orderlies, \$90, an increase of \$13, and surgical orderlies, "a greater sum than this"; ward maids, \$70, a \$3 raise; seamstresses, \$76, as at present; matrons, \$76; housekeepers, \$88; gardeners, \$80; wall-washers, \$100; doormen, \$90, and utility janitors, \$100.

The hours of employment were set at eight hours for a six-day week.

Since the hospitals believed it impossible at this time to abolish board as part of the wages, the sum of \$22 a month for board for a six-day week and \$10 a month for room were set as maximum living costs to be deducted from employees' wages.

The total increases mean a pay increase of \$150,000 a year to the 1,400 hospital employees. Charges to patients will be increased approximately 75 cents a day per bed at all Seattle hospitals to cover this increase on their budgets. This will make a ward rate of \$4.25 a day.

The council also has notified the state workmens' compensation commission that after October 15 the daily ward rate charged in Seattle would be the same as to private patients. The most this group has ever paid has been \$3 per day and certain drug allowances. Hereafter the hospitals will furnish certain drugs free.

Nurses Brought by Bus Two Miles to Hospital

Nurses now go back and forth between the Butler County Memorial Hospital, Butler, Pa., and the nurses' home, two miles distant, in the same manner that school children are transported—in a school bus.

During the summer months the old Butler General Hospital building, which recently had been converted into an apartment building, was remodeled and equipped as a nurses' home. Although the Butler County Memorial Hospital was built twelve years ago, no provision had been made until this time for a nurses' residence away from the hospital. The nurses were housed on the third floor of the main hospital building.

During late summer forty-two nurses were transferred to the newly equipped building. New furniture was purchased, as well as a school bus for transporting the personnel. The home is large enough to accommodate twenty more students than are now enrolled in the nursing school. Only about six minutes' time is required for the two-mile trip to the hospital, although it is an expensive procedure, according to Mabel G. Wilson, superintendent of the hospital. This is because most of the nurses are on eight-hour duty and many trips must be made in twenty-four hours to and

fro between the hospital and home.

The third floor of the hospital was renovated and equipped as a maternity department. It gives the hospital twenty extra beds and releases the present maternity department for use of the pediatric wards.

All expenditures for remodeling and equipping, totaling \$36,000, were contributed by the Community Chest of Butler, which gives more per capita to its Community Chest than any other city in the country.

Outdoor Advertising Used in Syphilis Program

A new outdoor poster panel, the first designed in connection with the syphilis education program in New York State, twenty-four-sheet billboard size, will be ready for release early in 1938.

It was developed by the New York Department of Health in cooperation with the New York committee on tuberculosis and public health of the State Charities Aid Association. Both national and state outdoor advertising associations have officially approved the poster and have agreed to provide free space and posting service. The painting is by an advertising staff artist.

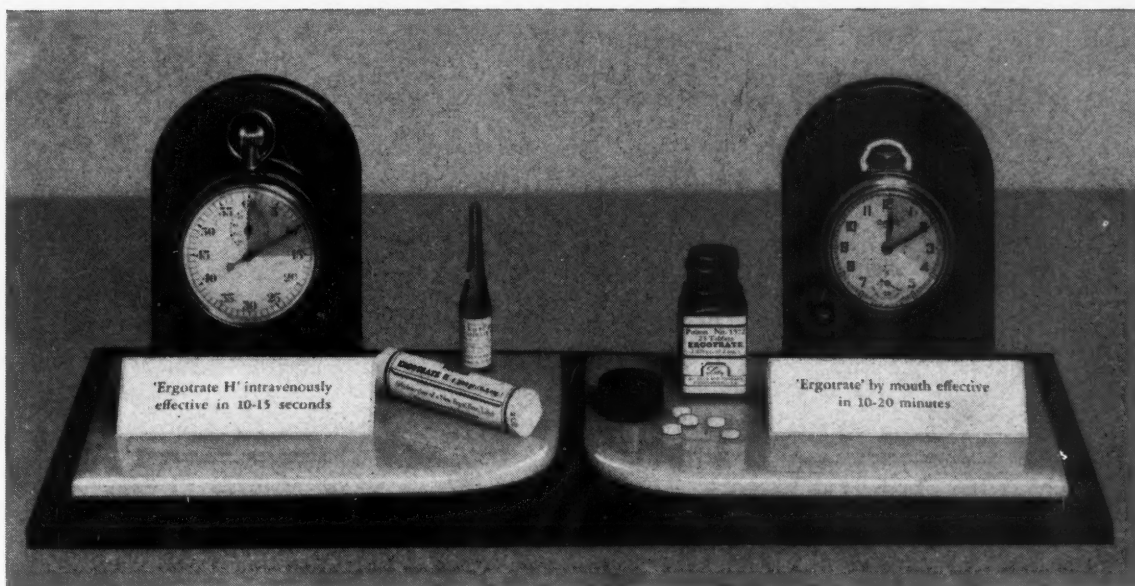
The panel is being offered for sale throughout the United States and Canada by the state committee on tuberculosis and public health.

Commenting on the panel recently, Dr. Edward S. Godfrey, Jr., state commissioner of health, said:

"The eradication of congenital syphilis is predicated in large measure upon the early diagnosis and treatment of the syphilitic expectant mother. By emphasizing the need for careful physical examination and blood testing early in pregnancy, this poster should be a material aid to health agencies and officials in their efforts to secure complete cooperation of the people in preventing the prenatal transmission of this disease."

Organize Cancer Clinic

A cancer clinic has been organized as a unit of the part-pay medical and dental clinics at the Berkeley General Hospital, Berkeley, Calif., upon recommendation of Dr. J. M. Flude, western field representative of the American Society for the Control of Cancer. The clinic will coordinate its activities with the nationwide cancer program. It will be conducted under standards approved by the American College of Surgeons and will be available for those patients not totally indigent but still unable to pay the full rates for this expensive work. To determine eligibility, patients must be approved by the social service department and recommended for part-pay care by their family physicians.



'Ergotrate' and 'Ergotrate H'

● This new ergot base which has recently been isolated in pure form supplies all the desirable therapeutic activity of choice medicinal ergot. Both the ampoule and tablet are in steady demand.

Ampoules 'Ergotrate H' (Hydracrylate of a New Ergot Base, Lilly) are supplied for parenteral use. The solution is permanent and stable. Intravenous injection

is followed immediately by uterine contractions.

Tablets 'Ergotrate' (Maleate of a New Ergot Base, Lilly) are used orally. Absorption from the stomach is rapid and the oxytocic effect well sustained.

These products are indicated to control postpartum hemorrhage and promote uterine involution. Sold through the drug trade.

ELI LILLY AND COMPANY

PRINCIPAL OFFICES AND LABORATORIES, INDIANAPOLIS, INDIANA, U. S. A.

Commonwealth Fund of New York Opens Eighth Rural Hospital During October

The opening of the North Mississippi Community Hospital at Tupelo, October 3, has given the northeastern part of that state a modern, fireproof, well-equipped fifty-bed hospital held in trust for the public, open to all qualified physicians and designed to serve the sick without discrimination.

This is the eighth such hospital to be built with the aid of the Commonwealth Fund of New York, which is now undertaking to provide one new hospital each year for a predominantly rural community, which will agree to meet its share of costs and to run the institution in accordance with generally accepted standards. The ninth in the group is now under construction at Ada, Okla., and the tenth has been awarded to the community centering in Provo, Utah.

The fund began this project in 1926 as an experiment in meeting the need of rural communities for better medical and other health services. Since adequate hospital facilities were lacking in many rural districts, recent graduates from medical schools were not entering rural practice in proportion to local needs, and in spite of substantial progress in some parts of the country, health services in rural areas were not so well developed as those usually found in cities. Well-planned and well-conducted hospitals were constructed to correct this situation. Experience in half a dozen different states indicates that this action has been justified.

The present plan is to aid in establishing hospitals having a capacity of between twenty-five and fifty beds

and easily accessible to a rural community having a population large enough to make good use of such accommodations and capable of meeting operating costs. The hospital may either be a totally new institution or may replace existing facilities which are clearly inadequate. The fund furnishes plans, specifications and architectural supervision for the construction, and not less than \$200,000 as a contribution toward capital costs. It advises in the organization of the hospital corporation and the medical staff, offers assistance in meeting the administrative problems of the early years, and provides a number of fellowships for postgraduate study by members of the medical staff.

Communities needing a fifty-bed hospital are required to raise from \$40,000 to \$60,000 for their share of the capital cost and must provide in addition a site (with service connections) and from \$10,000 to \$15,000 to meet the deficit of the first year's operation. Ownership and administrative responsibility are lodged in a local corporation, organized not for profit, which contracts with the fund to operate the hospital in agreement with specified standards. These standards are such as to guarantee its integrity as a community institution and to justify its approval by the American College of Surgeons.

Hospitals founded under this program are now operating in Murfreesboro, Tenn.; Farmville, Va.; Glasgow, Ky.; Farmington, Me.; Wauseon, Ohio; Beloit, Kan., and Kingsport, Tenn.

Overcrowded Institutions Halt Sex Crime Reduction

As the result of overcrowded conditions in New York State institutions, 150 mentally defective persons in Brooklyn alone are free to associate with the public while awaiting commitment to a state school. This fact was revealed recently in testimony before the legislative committee investigating sex crimes. Although the need for commitments was reported as urgent, the two institutions available to the city, Letchworth Village and the Wassaic State School, could not care for all the feeble-minded.

Dr. Gladys McDermaid, alienist in the mental hygiene clinic of Kings County Hospital, told the committee that admissions to Letchworth Village and Wassaic had been closed except during a few intervals, for the last two or three years. She pointed out that an institution was needed near by to handle emergency cases.

Young Snite in Florida

Fred B. Snite, Jr., who was brought from China to Chicago a few months ago in an "iron lung" for hospitalization, will spend the winter in a three-room sun suite atop a beach home at Miami Beach, Fla. Attended by twenty-two persons, relatives, physicians and nurses, he arrived recently in Miami Beach by train from Chicago. His father estimated he was spending \$1 for each breath drawn by his son. The \$2,300 "iron lung" functions at the rate of \$15 a minute. The cost during the trip was \$20,000 a day.

Participates in Fair

The Reading Hospital, Reading, Pa., participated in expositions at the Reading Fair with a booth displaying x-ray films, a new ultra short wave diathermy machine and motion pictures; a woman's auxiliary booth, and also at the Red Cross first aid station an ambulance, with a nurse and physician in attendance.

\$75,000 Anniversary Fund Sought Through Contribution

Knickerbocker Hospital, New York City, through its officials has made an appeal for contributions to a seventy-fifth anniversary fund of \$75,000 for a new clinic building and other improvements and expenses, chiefly for its eleemosynary work among children.

Walter Mezger, superintendent, reported that the hospital treats about 400 children a month. During September 178 children were taken to the hospital's accident room, besides those who arrived in ambulances. Last winter as many as 175 ambulance calls a month were made for children ranging from early childhood to 14 years of age.

Last year the hospital gave 38,549 hospital days of care to men, women and children, of which 16,560, or 42.9 per cent, were free. Clinic visits in its out-patient department totaled 39,216; of these, 27,957, or 71.1 per cent, were free.

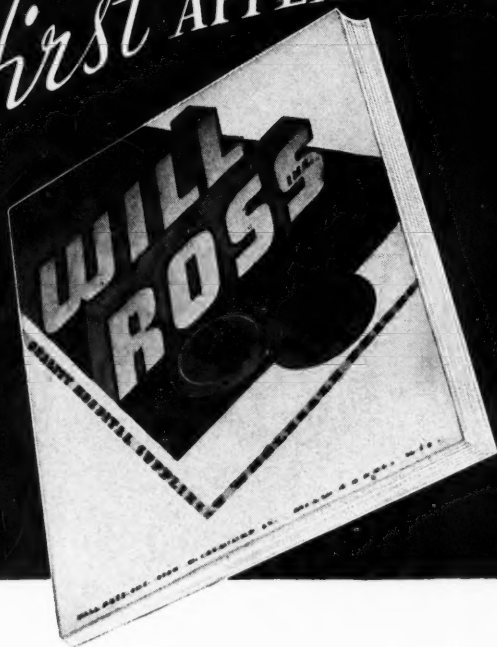
Coming Meetings

- Colorado Hospital Association.**
Annual convention, Denver, Nov. 9-10.
- Alberta Hospitals' Association.**
Next meeting, Edmonton, Nov. 15-17.
- Council on Medical Education and Hospitals, American Medical Association.**
Next meeting, Chicago, Feb. 14-15.
- Association of Western Hospitals.**
Next meeting, San Francisco, Feb. 28-Mar. 3.
- Western Conferences of the Catholic Hospital Association.**
Next meeting, San Francisco, Feb. 28-Mar. 3.
- Ohio Hospital Association.**
Next meeting, Columbus, April 5-7.
- American Nurses' Association, National Organization for Public Health Nursing and National League of Nursing Education.**
Biennial convention, Kansas City, Mo., April 24-29.
- Pennsylvania Hospital Association.**
Next meeting, Pittsburgh, April 27-29.
- Pennsylvania Association of Nurse Anesthetists.**
Next meeting, Pittsburgh, April 27-29.
- Pennsylvania State Dietetic Association.**
Next meeting, Pittsburgh, April 27-29.

More Aged in N. Y. C. Institutions

Old age assistance and its liberalization of the public pension system, have not reduced the population of New York City's homes for the aged, and have not decreased the city's expense for their care as was popularly expected, Dr. S. S. Goldwater, city hospitals' commissioner, has announced. There are now 109 more aged people in City Home on Welfare Island than there were in 1936, an increase of 7 per cent. Though technically eligible to receive old age assistance, they were obviously incapable, physically, of caring for themselves, Doctor Goldwater said.

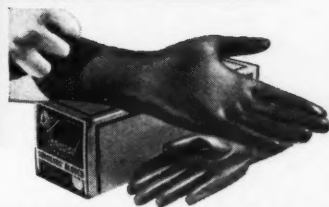
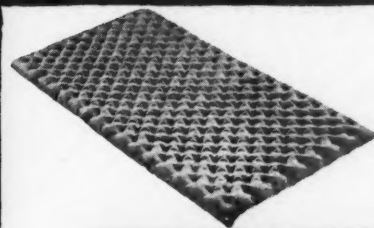
First APPEARANCE



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**NEW, INTERESTING
ITEMS in the 1938
WILL ROSS CATALOG**

Kenwood Air Mattress

A new low priced air mattress. Bed weary patients will welcome the relief this mattress provides. Made especially to our own specifications, on a quantity basis which enables us to offer it to you at a phenomenally low price.

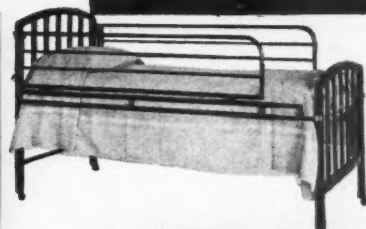


Brown Latex Gloves

Made of pure, virgin latex, these gloves have inherent qualities which insure long life and full service under the rigors of frequent sterilization. Brown in color, they overcome the subconscious objection many surgeons have to light colored gloves. And the price is interesting.

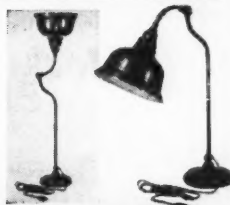
Portable Bedsides

Of inestimable value as protection against "rolling-out-of-bed" accidents. Fit any bed. Easy to attach, easy to install, fold down in a jiffy. Exceptionally sturdy in construction, made of good quality steel tubing... finished in brown and mahogany to match beds. A much-needed safety accessory.



New Bedside Lamp

A novel and practical idea in a bedside lamp... combining special design which provides "extra reach" with two intensities illumination and indirect lighting. Double filament lamp gives bright light for reading, examinations, etc., and subdued night light. Shade may be inverted for soft, indirect general illumination.



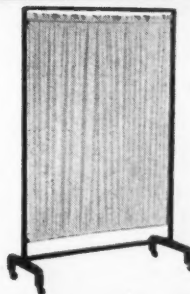
Wood Furniture

A new line of beautifully made, handsomely finished wood furniture for patients' rooms, dormitory, dining room, lobby, etc. Practical in construction. Made of enduring Vermont Rock Maple in authentic designs appropriate for hospital service.



Bedside Screens

Made of modernistic square tubing that harmonizes with up-to-date room furnishings. Adds note of distinction to any room. Three-inch up-and-down adjustment at top and bottom... keeps screen neat and taut at all times. Available in three colors... white, ivory, and plain walnut.



EVERY year, now, dating from a modest start in 1914, Will Ross has been sponsoring "first appearances" of new, interesting merchandise. This year, the most comprehensive Will Ross catalog on record brings to you many new, choice selections... each with a specific hospital application.

Gathered together from the most dependable manufacturing sources at home and abroad, the Will Ross line now includes more than 6,000 items... offering hospitals and sanatoria the widest possible choice for judicious, selective buying. Hospital needs have been met, in some instances, by establishing our own manufacturing plants... designing and creating those things which the market could not supply in conformance to Will Ross standards.

The 1938 Will Ross catalog has been put in the mails... making easily available to every hospital in the country the items required in daily service. If for any reason you have not received your copy, tell us. We shall be glad to send another.

WILL ROSS, Inc. 3100 W. CENTER STREET
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Manufacturers and Wholesale Distributors of Hospital Supplies



A 2119-1P (1137)

Harmon Foundation Releases New Film Portraying Nursing Education Process

By Elizabeth B. Sterling

A moving picture "Nurses in the Making," a two-reel, 16-mm., silent film has just been released by the Harmon Foundation to portray the place and function of the nursing school, and to give the public a good conception of nursing services. The film takes about half an hour to show, and can be presented in any room or auditorium, the only equipment necessary being a suitable projector and screen.

"Nurses in the Making" was made by the Harmon Foundation in coop-



Measuring milk in a laboratory, steps in preparing for an operation or pharmacy methods can be easily taught with motion pictures.

eration with the New York Hospital School of Nursing. Although it was filmed at New York Hospital and at the Henry Street Visiting Nurse Service, the material is general and suitable for showing by any good school or hospital. The film was intended to give audiences basic information about entrance requirements to nursing schools and the curriculum offered student nurses.

The picture opens with scenes of graduate nurses working in a hospital, a home, in public health, in a school, in an industrial plant, with the Red Cross and with the Frontier Nursing Service. After surveying some of the major fields of service open to the graduate, the film shows the standards of health, education and character which are set by a nursing school today.

It then takes the audience through the various phases of the curriculum. New students are shown being given health examinations, and health supervision throughout the three years is indicated; shots of chemistry, bacteriology and anatomy classes give an idea of the sciences studied. A view of a class in nursing practice shows the careful preparation given students before they are first permitted to care for patients. In later scenes of the film, students are being given instruction and experience in nursing care in the various services of the hospital, and, during a two months' affiliation, applying principles of nursing technique in the home.

Prints of this film may be secured for a single showing at a cost of \$3.00 plus transportation. Prints may also be leased on a lifetime basis. The film is accompanied by mimeographed "Suggestions for Use," which supply reading lists and detailed information on nursing education. A list of records and instructions for playing them also are included. Orders or inquiries should be addressed to the Harmon Foundation, 140 Nassau Street, New York, N. Y.

Nurses Hear Provisions of N. Y. Licensing Bill

A bill requiring licensing of all New York State nurses, those fully qualified to care for acute cases, as well as practical nurses to care for convalescents or chronic cases in the home, was the subject of lively discussion at the meeting of the New York State Nurses' Association recently at Lake Placid, N. Y.

Marion Sheehan, director of the division of public health nursing of the state department of health, outlined the proposed bill to the convention

delegates and described its purposes.

The bill, she declared, will define what constitutes the practice of nursing and set up a system of penalties to be imposed upon those found practicing without a license so that "the full protection of the law can be assured the public."

Among liberal features suggested was one permitting all qualified out-of-state nurses to register in New York State upon presentation of credentials satisfactory to the state education department.

Offers Heart Disease Lectures

A series of twelve bi-weekly lectures on diseases of the heart, inaugurated last year, will be repeated by the New York Heart Association of the New York Tuberculosis and Health Association again this year, beginning November 9. The course is endorsed by the New York Academy of Medicine. It is designed to give the general practitioner a better understanding of problems pertaining to the treatment of certain types of heart disease.

Nurses May Win College Degree

The University of Pittsburgh, in cooperation with the Elizabeth Steel Magee Hospital school of nursing, will offer a special course for graduate nurses. The new program is designed so that graduate nurses who do not have college degrees may win them.

Moves Headquarters to Chicago

The National Association of Nurse Anesthetists, which is moving its headquarters to Chicago, will occupy office space in the American Hospital Association building at 18 East Division Street. Anna Willenborg, St. Joseph's Hospital, Chicago, has been appointed executive secretary. The office of the treasurer, Gertrude L. Fife, will remain, 2065 Adelbert Road, Cleveland.

Parkview Award Made Event

Parkview Hospital, Plymouth, Ind., the winner of the Parke, Davis & Co. National Hospital Day publicity trophy in the small hospital classification, capitalized further upon this publicity by making the presentation an event in the community. A luncheon was given on October 13, and Plymouth civic clubs, the hospital board, newspapermen, the hospital council and guest speakers attended.

Hospital Name Changed

The name of the Sternberger Children's Hospital, Greensboro, N. C., has been changed to the Sternberger Hospital for Women and Children.

Best Foot Forward

STUDENT nurses put their best foot forward, gain confidence, go about their work with cheerful assurance when they wear well-cut, well-designed Marvin-Neitzel uniforms.

Look at other lines, compare the fabrics, the workmanship. Ask about color and shrinkage. Marvin-Neitzel uniforms are designed from fabrics, Sanforized-shrunk, accurately cut and carefully sewn. They have a dashing style that makes you proud to look over your entering class.

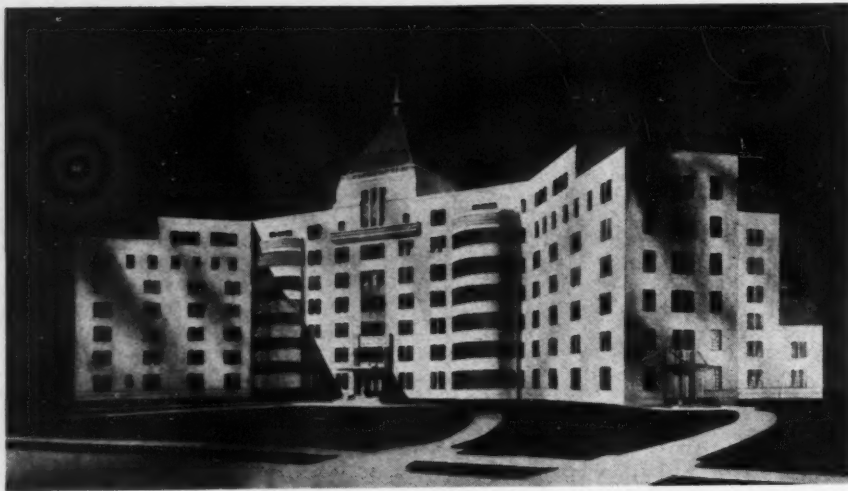
Our representative will be glad to call and talk over your requirements

MARVIN-NEITZEL CORPORATION

"Everything from Cloth for the  Hospital and School of Nursing"

TROY — Since 1845 — NEW YORK





Sketch of the new Psychiatric Building of Kings County Hospital.

N. Y. C. Launches Two New Projects During October

With caustic comment upon the neglect of the sick by previous New York City administrations, Mayor F. H. La Guardia on October 5 placed the cornerstone of the partially-completed \$7,000,000 Hospital for Chronic Diseases on Welfare Island, the largest of its kind in the world.

The hospital is composed of four identical four-story pavilions housing a total of 1,600 patients. The pavilions are grouped in twos around the administration building, a five-story structure, which will hold offices, kitchen and dining rooms, laboratories and therapeutic and diagnostic divisions. Each floor of the pavilions will have a sun porch running the length of the building.

Also included are a \$1,610,000 nurses' home with a bed capacity of 688, and a \$268,762 power plant.

The hospital will treat all chronic diseases except tuberculosis, mental ailments, cancer and neurosis. The department of hospitals will be affiliated with the Columbia University College of Physicians and Surgeons, the Cornell University Medical College and the New York University College of Medicine in the operation of the hospital.

Another project of the department of hospitals was begun with the order from Dr. S. S. Goldwater, commissioner of hospitals, for wrecking of the musty 106-year-old firetrap that houses some of the chronic and mental patients of Kings County Hospital. First to rise on the site of the old structure will be a nine-story Chronic Disease Pavilion, costing \$2,750,000. It will have 750 beds and will be completed in one year. This job will be followed by erection of the Psychiatric Building, which will house 300 patients in accommodations costing \$1,500,000.

NEW BUILDING PROJECTS

ALTON, ILL.—Two hospital buildings, the total cost of which will be in the neighborhood of a million dollars, are near completion. St. Joseph's Hospital and the Alton Memorial Hospital dedicated new buildings during October.

NORRISTOWN, PA.—A completely new and enlarged Montgomery Hospital has been assured here through the oversubscription of a \$525,000 building fund campaign during October. A total of \$557,292 was subscribed for the new 130-bed hospital by approximately 4,500 contributors. Diagnostic and therapeutic equipment in the new hospital will be complete and modern. Architects are the Balingier Company, Philadelphia.

JERSEY CITY, N. J.—Dedication ceremonies and the laying of the cornerstone of the new \$3,000,000 Hudson County Tuberculosis Hospital will take place on November 4, Dr. B. S.

Pollak, medical director of the hospital, has announced. The hospital, one of the county units of the Jersey City Medical Center, will provide 525 beds for tuberculous patients, and will be the most modern and completely equipped tuberculosis hospital in the country. The twenty-three-story structure will not be ready for occupancy until after the first of the year, as many of the rooms and departments have yet to be furnished and equipped.

GLENS FALLS, N. Y.—Work will begin at once on the new wing to the Glens Falls Hospital and on the remodeling of the existing structure. Construction and remodeling costs will involve an expenditure of \$500,000, and will provide the institution with much needed facilities. Milton L. Crandall, Glens Falls, is the architect and Charles F. Neergaard, New York City, technical consultant.

GREENBURGH, N. Y.—Excavation

for the erection of the new group of buildings which will house the New York School for the Deaf on Knollwood Road was started recently. The school has seventy-six acres of land. Six major buildings and a superintendent's cottage will be constructed. The main buildings will include two dormitories, gymnasium building, dining hall and service building, academic school, administration building and a vocational school building. An athletic field also will be constructed.

NEW YORK CITY.—Latest wrinkles in sanitary housing and comfort are included in plans for the new \$100,000 nurses' home under construction as an adjunct of the Victory Memorial Hospital. The new structure will have wardrobes and furniture of pressed steel and baked enamel. It will be ready for occupancy in February, 1938.

NASHVILLE, TENN.—The eight-story addition to Vanderbilt University Hospital and Medical School, which will cost approximately \$800,000, is expected to be completed next spring. Construction was started in December, 1936.

TOLEDO, OHIO—Repair work on the Toledo State Hospital unit partially burned during April is now under way. Dr. O. O. Fordyce, hospital superintendent, estimated the work could be completed in ten days.

Social Disease Campaign Gains Momentum in Cities

With St. Louis planning to launch a campaign against syphilis similar to the one in Chicago, and with Omaha, Neb., carrying the fight against social diseases into the public schools, the campaign against venereal diseases is gaining gradual momentum throughout the country.

Mrs. James E. Grossman, president of the St. Louis women's chamber of commerce, and Dr. Richard S. Weiss, president of the Missouri Social Hygiene Association, are agitating for the fight in that city.

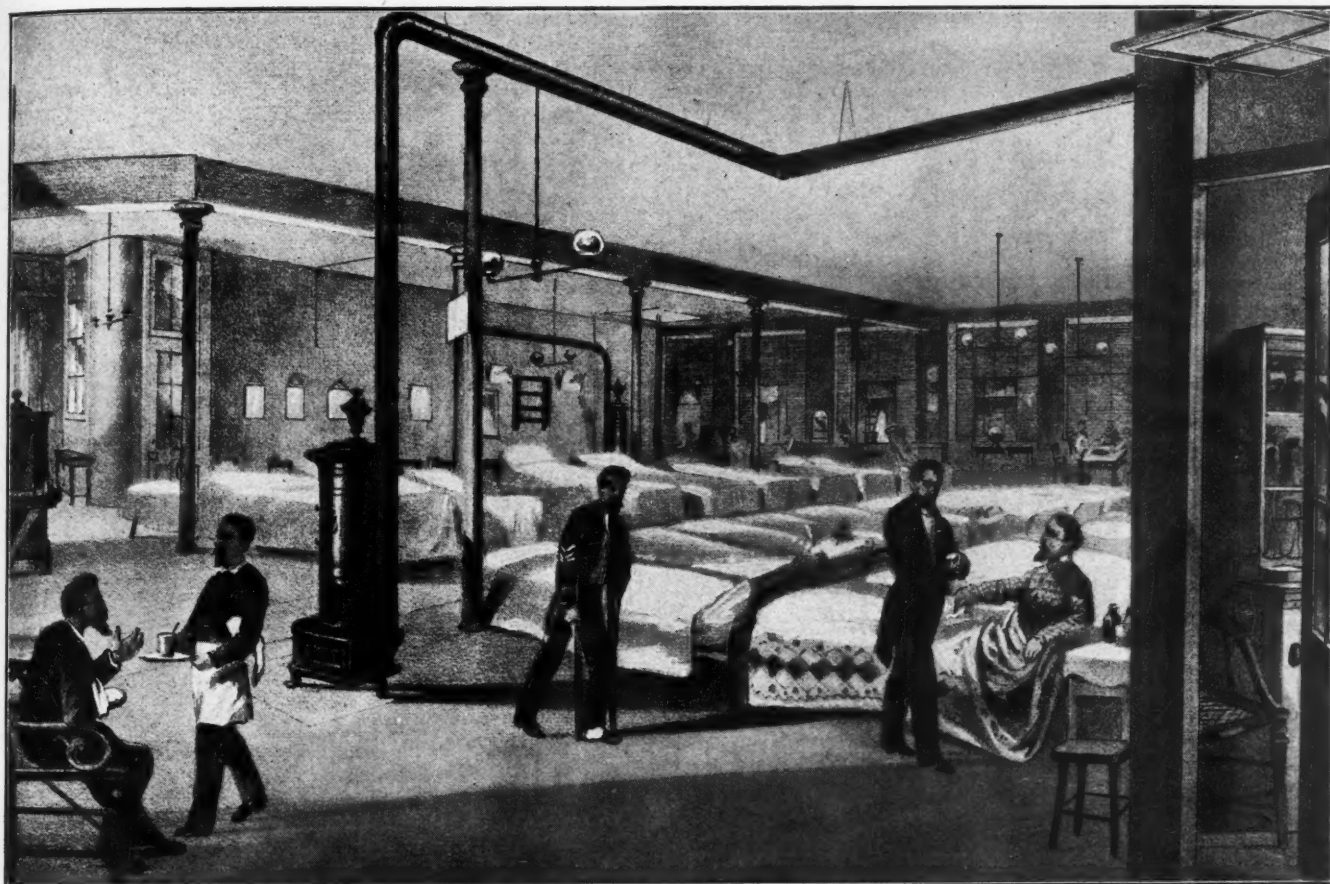
Omaha's board of education has asked WPA for aid in financing a series of educational lectures in its high schools, operating under the city health department. The city would furnish supplies, space and equipment; the WPA, trained nurses and clerks.

Meanwhile the New Jersey state board of health voted to support legislation to make premarital venereal disease tests compulsory.

Surgeon-General Brings Out Book

Surgeon-General Thomas Parran of the U. S. Public Health Service, is the author of a new book, "Shadow on the Land: Syphilis," published by Reynal and Hitchcock, New York City. The book gives authoritatively the information which every person needs to understand the campaign.

During The Uncertain 'Sixties Hospitals Depended on Webb's Alcohol



SOLDIERS DEPOT HOSPITAL IN 1864

T. F. Healy Collection

"It has not its equal in any other State in the Union." This was said about the Soldiers Depot Hospital, located at 50-52 Howard Street, New York, in 1864. Shown at the right of the picture is the dispensary from which were issued many preparations made with alcohol, for the healing and comfort of the sick.

GONE is the hospital of the eighteen sixties. Crude coal stoves, flickering gas lamps—so many of the things that were uncertain—have given way to an entirely new and complex institution: the modern hospital, alert to the times and stronger than ever before.

In the space of three generations the science of caring for the sick has changed to an incredible degree. But as less useful materials have vanished or have been replaced, alcohol has steadily become more indispensable to hospitals.

Those who enter a hospital are scarcely conscious of their dependence on alcohol. Yet it is everywhere—in the pharmacy, operating room, maternity ward and laboratory. It has no substitute.

When hospitals use pure alcohol, they turn to Webb's and U. S. I.—U. S. P.—the leading brands. As far back as 1835, Webb's was their standard. Since Webb became a part of the U. S. Industrial

Alcohol Co. in 1915, they place equal confidence in both products. To insure highest quality and uniformity insist on U. S. I. products.

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Accrediting Committee for Nursing Schools Formulates Plans for Next Year's Progress

Toward improvement in the preparation of nurses and quality of nursing service, the committee on accrediting of the National League of Nursing Education has appointed a full-time secretary to expedite progress of the committee's objective. Clara Quereau, former secretary of the board of nurse examiners of New York State, assumed this post on October 1.

Believing that counsel of all related organizations is of vital importance in accrediting schools of nursing, the committee asked allied associations to appoint representatives to serve as consultants. The personnel of the consulting group includes Dr. Nathaniel Faxon, Massachusetts General Hospital, Boston, and the Rev. John Martin, Hospital of St. Barnabas, Newark, N. J., representing the American Hospital Association; Dr. M. N. Newquist, Chicago, the American College of Surgeons; Dr. William D. Cutter, Chicago, the council on medical education and hospitals of the American Medical Association; Marion Howell, Cleveland, the National Organization for Public Health Nursing, and Mrs. Ethel Clarke, Bridgeport Hospital, Bridgeport, Conn., the American Nurses' Association.

From the field of general education, three outstanding educators will act as consultants. They are Prof. George A. Works, dean of students and university examiner, University of Chicago, who is secretary of the commission on institutions of higher education of the North Central Association; Prof. Edward S. Evenden, Teachers College, Columbia University, and Father Alphonse Schwitalla, dean, St. Louis University School of Medicine, and president of the North Central Association.

A conference with consultants to the committee on accrediting, similar to the one held in April, was held on October 30, at which time plans for the coming year were formulated.

The nurses who are serving on the accrediting committee represent institutions of various types and widely dispersed geographical areas.

Members of the executive committee are: Anna D. Wolf, chairman, New York Hospital, New York City; Stella Goostray, vice chairman, Children's Hospital, Boston; Elizabeth Burgess, Teachers College, Columbia University, and Bernice Anderson, Mountinside Hospital, Montclair, N. J. Nellie X. Hawkinson, University of Chicago, president of the National League of Nursing Education; Claribel A. Wheeler, executive secretary, and Miss Quereau are *ex officio* members of this committee.

Committee members at large include

the following: Helen Lehmann, Baylor University Hospital, Dallas, Tex.; Elizabeth Odell, Evanston Hospital, Evanston, Ill.; Edna Peterson, Jewish Hospital, St. Louis; Charlotte Pfeiffer, Stuart Circle Hospital, Richmond, Va.; June Ramsey, Harper Hospital, Detroit; Sister Mary Laurentine, St. Francis Hospital, Pittsburgh; Sister Mary Berenice, Marquette University, Milwaukee; Olive Slocum, Hospital of the Good Samaritan, Los Angeles; Harriet Smith, Harborview Hospital, Seattle, and Daisy Dean Urch, College of Saint Teresa, Winona, Minn.

Vital Statistics Compiled

The births and deaths of Denver now fill 249,283 individual typewritten cards in alphabetical order. The task of transferring vital statistics from the books of the Denver General Hospital dating back to 1887, has just been completed by twenty-one employees of the Works Progress Administration. Formerly, when any representative of an insurance company or pension official came to the hospital for vital statistics it was necessary to look through all the books to find the name, which meant hours of tedious research. Much valuable information has been gained.

BEQUESTS AND GIFTS

OXFORD, ENGLAND.—Lord Nuffield, automobile manufacturer and philanthropist, recently gave 300,000 pounds (nearly \$1,500,000) to the Radcliffe Infirmary. He previously had given 150,000 pounds (about \$750,000) to the hospital. The second donation is in the form of an endowment fund, the income from which is to be devoted to raising the standard of the infirmary. Lord Nuffield's benefactions in the last eleven years total some \$40,000,000, including a gift of \$10,000,000 to Oxford University.

NEW BEDFORD, MASS.—Sol-e-Mar Orthopedic Hospital for Children will receive approximately \$200,000 as its share of the rest and residue of the estate of the late Amelia H. Jones. Miss Jones, the daughter of a whaling merchant, died in 1935, leaving \$200,000 in specific public bequests, including \$50,000 for St. Luke's Hospital, New Bedford. In addition to the bequest made to the Sol-e-Mar Hospital, the institution was left a trust fund of \$90,000. The hospital was her own inspired benefaction, constructed and maintained at a cost of \$1,000,000.

BRYN MAWR, PA.—Bryn Mawr Hospital recently opened a \$1,000,000 "pay-off-the-mortgage" campaign and

received three surprise gifts of \$10,000 each from hospital trustees.

NEW YORK, N. Y.—Mount Sinai Hospital will receive \$916,579 as the residuary legatee under the will of the late Marco Fleishman, tobacco merchant. The bequest is to be known as the Rosetta and Marco Fleishman Fund and will be used for construction and equipment of a new building or extension of the existing buildings to care for persons in the early stages of tuberculosis. In addition to this bequest, the hospital is to receive the principal of trust funds amounting to \$270,000 on the deaths of various persons for whom the trusts were created.

NEW YORK, N. Y.—Bequests totaling \$168,272 were received by the United Hospital Fund during last year, Homer Wickenden, general director, has reported in the fund's fifty-eighth yearbook. The largest bequest, \$162,122, came from the estate of Reid A. Kathan, law book publisher, who died in 1929. The fund also has an interest in twenty-two estates now in process of settlement.

ROCHESTER, N. Y.—Highland Hospital has received a gift of a new building to be devoted exclusively to maternity patients from Louie Alice Hall. The building will be erected as a memorial to her sister, the late Julia B. Hall. The terms of the gift include the complete furnishings as well as the building, which will be of forty-six-bed capacity. It is to be a three-story structure, erected to harmonize with the existing building, apportioned with wards and private rooms.

PROVIDENCE, R. I.—Among the gifts made to Brown University during the past academic year is \$331,570 from Dr. Charles Henry Hare, a Boston surgeon, for construction and endowment of a new infirmary, to be known as Andrews House, in memory of Elisha Benjamin Andrews, who was one of Brown's most beloved presidents.

SUMTER, S. C.—Neill O'Donnell, for fifty years active in the business life of Sumter, died recently leaving the bulk of his estate, estimated between one-half and three-fourths of a million dollars, to the Tuomey Hospital, a general hospital of 100 beds serving the city and county of Sumter and the adjoining counties of Clarendon and Lee.

CHARLESTON, S. C.—Roper Hospital was the recent recipient of a gift of \$75,000 from Victor A. Morawetz, New York City lawyer, to be used in constructing a wing for the treatment of Negro patients with contagious diseases.

BELLINGHAM, WASH.—A pioneer wholesale grocer, the late Peter P. Lee, left a provisional bequest of \$20,000 for construction of a Protestant hospital or a city hospital in this city.

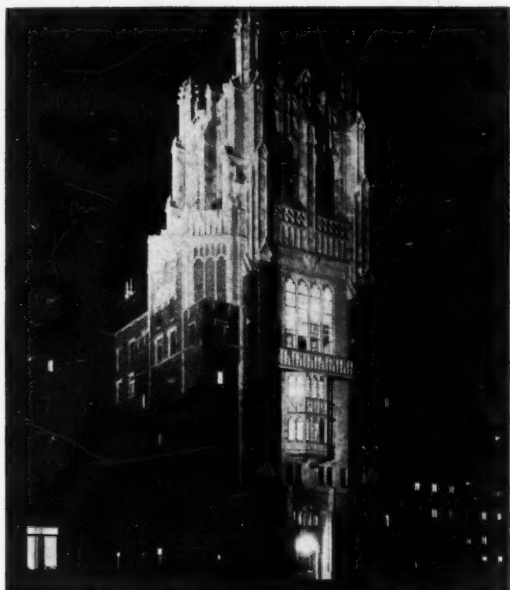
BROOKLYN, N. Y.—An initial contribution of \$76,850 started the \$600,000 building fund drive of the Israel Zion Hospital recently.

IDEAL FOOD CONVEYORS

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10 Years Day-in and Day-out Service

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Night view of the tower of the 800-bed General Hospital, State University of Iowa, Iowa City, Iowa.



Section of the large, well equipped central diet kitchen.



Partial view of the battery of 18 Ideal Food Conveyors on regular duty here at the General Hospital.



Serving 130,000 to 140,000 "kitchen-hot" meals a month—smack on the stroke of each meal time—is more than an ordinary task in this great state institution. Its 800-bed theoretical capacity (675 patients, on average, served by conveyor method) is confined to 4 floors. Horizontal distances are extensive. Yet, every patient, no matter how far situated from the central diet kitchen, receives a delicious, piping-hot meal—food kept right at the proper serving temperature, as hot as if it were served at the kitchen table. Meal service is concluded within a brief 20-minute period. The Iowa State University General Hospital uses 18 Ideal Food Conveyors. The first were installed over ten years ago. Not until recently, after 10 years constant usage, was there need on a single one of them for even minor repairs. A tribute to the built-in durability and dependability of Ideal equipment.



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NAMES IN THE NEWS...

Administrators

DR. WINFRED OVERHOLSER of Wellesley Hills, Mass., widely known psychiatrist, has been appointed superintendent of St. Elizabeth's Hospital, Washington, D. C., a government-operated institution for mental cases. Doctor Overholser, in recent months, has been doing special work for the National Committee for Mental Hygiene in New York. He formerly served as commissioner of the Massachusetts department of mental diseases.

DR. S. M. BITTINGER, former assistant superintendent and associate medical director of North Carolina Sanatorium, at Sanatorium, is the assistant superintendent and medical director of the new Western North Carolina Sanatorium, at Black Mountain, opened in October. DR. P. P. MCCAIN, superintendent at Sanatorium, will head the new institution also.

DR. JAMES G. ANDERSON, Petaluma, Calif., recently was named Sonoma County physician and head of the Sonoma County Hospital, Santa Rosa, Calif., to succeed DR. S. S. BOGLE, who resigned after serving twenty-six years. Doctor Bogle resigned as a protest against drastic changes in operation of the hospital and county poor farm put into effect by the board of supervisors.

DR. GEORGE T. MCMAHAN, Burnet, Tex., has been named superintendent of a new hospital for mental diseases to be built in West Texas.

IRVING CHIRPIN, formerly of the Cedars of Lebanon Hospital, Los Angeles, Calif., has been appointed as-



Dr. Winfred Overholser (center) being sworn in as superintendent of St. Elizabeth's Hospital, Washington, D. C. At the right is Harold L. Ickes.

sistant superintendent of the Beth Abraham Home for Incurables, New York City.

CLARALEE CLINE, R.N., head surgical nurse at the Dr. John Warner Hospital, Clinton, Ill., for the last two years, succeeded MRS. FRANCES WOOD, who resigned, as superintendent on November 1.

W. E. AVERY, JR., of Columbia, S. C., is the new business manager and superintendent of the Ware County Hospital, Waycross, Ga.

AMY E. BIRGE, superintendent of the Holyoke Hospital, Holyoke, Mass., since 1928, has resigned that post on advice of her physician. She will conclude her services there November 1.

SISTER M. GILBERTO has been appointed director of nursing service at St. Elizabeth's Hospital, Youngstown, Ohio. Recently Sister Gilberto was elected a fellow of the American College of Hospital Administrators, awarded for ten years of successful hospital administration. Sister Gilberto was superintendent of St. Joseph's Hospital, Lorain, Ohio, for six years and superintendent of St. Joseph's Hospital, Warren, Ohio, for seven years.

L. A. JOHNSON, superintendent of Iowa Lutheran Hospital, Des Moines, since 1930, resigned on October 1 because of ill health. CLARA HENDRICKSON, office manager, will serve as acting superintendent until a new superintendent is chosen.

SISTER M. GERMAINE, former superintendent of nurses, has been appointed to the general superintendency of St. Elizabeth's Hospital, Youngstown, Ohio. She succeeds SISTER M. DE LELLIS, who is now at the mother house of the order of the Holy Humility of Mary at Villa Marie, New Bedford, Pa.

SISTER ALICE REGINA, for nine

years superintendent of St. Mary's Hospital, Passaic, N. J., has been appointed superior of St. Elizabeth's Hospital, Elizabeth, N. J., succeeding SISTER M. WILHELMINA, who has headed the institution for nearly two years. After a rest, Sister Wilhelmina will go to St. Joseph's Hospital, Paterson, N. J.

DR. JAMES L. COOPER has succeeded DR. PAUL C. PEDIGO as head of the McCamey Hospital, McCamey, Tex.

EDNA G. DAVIDSON, superintendent of the Miller Memorial Hospital, Duluth, Minn., since March, 1934, has resigned and been replaced by FRANCES ECKMAN, R.N. For the last year Miss Eckman has been superintendent of the St. Louis County Dispensary, Buhl, Minn. She was trained at the University of Minnesota and at St. Luke's Hospital school of nursing, Duluth.

DR. MORRIS S. WHEELER has been appointed superintendent of the Rusk State Hospital, Rusk, Tex., to succeed DR. WILLIAM THOMAS, recently made superintendent of the Terrell State Hospital, Terrell, Tex.

FANNY CARTER has resigned after twenty-one years of service as superintendent of the Alexandria Hospital, Alexandria, Va. MRS. MARGARET PAGE FAIR has been chosen as Miss Carter's successor. Mrs. Fair is a graduate of John Hopkins University, Baltimore, served eighteen months in France during the World War, and was assistant to the director of Garfield Memorial Hospital, Washington, D. C., for two years. She was then made superintendent of the Chatham Private Hospital, Chatham, N. Y. For the last eight years Mrs. Fair has been associated with M. F. HERNDON, hospital consultant, New York City.

DR. KENNETH KEILL has been appointed acting superintendent of Pilgrim State Hospital, Brentwood, L. I., succeeding DR. WILLIAM J. TIFFANY, recently appointed New York commissioner of mental hygiene. Doctor Keill was formerly assistant to Doctor Tiffany at Pilgrim State Hospital.

Deaths

DR. DUNCAN U. SAUNDERS, assistant superintendent, Eloise Hospital, Eloise, Mich., died recently of injuries sustained in an automobile accident. He joined the staff of Eloise Hospital sixteen years ago, and at the time of his death was in charge of the William B. Seymour Hospital, a branch of Eloise. He was a member of the Wayne County and Michigan State medical societies, and was graduated from the Detroit College of Medicine in 1906.

The REV. AUGUST DANIEL PFOST, superintendent of the Evangelical Deaconess Hospital, Brooklyn, since 1927, died recently in that hospital after a stroke of apoplexy. He was eighty-three years old.

(Continued on page 120)



Four department heads of Montefiore Hospital, New York City. They are William J. Overton, Charles E. Croft, Lenna F. Cooper and Dr. J. Masur.

SAFETY!

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Another car comes toward you from nowhere. A quick turn of the wheel, a screech of brakes, and a crash! A tree at the roadside stops you. But thanks to shatter-proof glass, injury is negligible, no ugly lacerations . . . Shatter-proof glass has greatly reduced driving hazards.



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READER OPINION

The Employee Speaks

Sirs:

The article signed by Dr. A. C. Bachmeyer for the Chicago Hospital Council's personnel relations committee, "Looking at Labor Unions," in the August issue of *The MODERN HOSPITAL* is much more than mere interesting reading. It creates an impression of genuine interest in the labor relationship in hospitals, as far as this is possible for an employer to whom the advice is directed. We believe that Doctor Bachmeyer is far ahead of the average hospital administrator because he recognizes this relationship to be a problem. We believe furthermore that he is entirely honest and completely sincere in his recommendations.

It is therefore in a spirit of intelligent understanding that this answer is given. In assuring our own sincerity, we expect to find as much understanding.

We believe that all persons who genuinely desire to solve this problem must necessarily recognize in time the correctness of our point of view and our choice of procedure since we are convinced that any other course of action will fail. And the person who works with intelligent understanding and an open mind toward the solution of our joint problem will not be prevented by prejudice from realizing the soundness of our position.

We admit that the foregoing might just as well have been said by Doctor Bachmeyer and the group which he represents, because as yet both sides are convinced of the correctness of our respective opinions.

Labor Relationships Are Similar

We would like first to enumerate the facts characterizing the relationship between the hospital and its employee in which we agree with Doctor Bachmeyer. He admits that this relationship resembles in certain respects the type of labor relationship found in commercial and industrial organizations. This, he says, is so because of the large employment of labor, because the hospital is the sole source of income for its employees, because of unfavorable working conditions in some institutions, lack of protection for the employee, paternalism from the side of the hospital, and some additional points.

In other words it is admitted that even if labor relations were fundamentally different from those in commercial enterprises, yet they show certain shortcomings of the latter which have precipitated, from labor's

side, unionization and the fight for better conditions.

Doctor Bachmeyer, however, attempts to show that, despite all these similarities, labor relations in the voluntary hospital are fundamentally different from those in commercial organizations.

First he tells us that the hospital expends considerable money for training its employees and in many instances receives in labor much less than the cost of education. We can assure him that he may hear precisely the same argument from any industrial administrator. It is by no means peculiar to hospitals.

Requires Therapeutic Atmosphere

The committee of the council goes on to say that the necessity of what it calls a therapeutic atmosphere, an atmosphere quieting and confidence-inspiring, as well as the particular type of work carried on in the hospital, namely, service to humanity, distinguish hospitals from the usual type of industrial organization. His points do characterize hospital work. However, it is apparent that they hold for all types of hospitals whether they are on a voluntary, private, or commercial basis.

We agree that the therapeutic atmosphere is vital to hospitals. However, we would like to ask how the hospital can expect to maintain this "confidence inspiring atmosphere" while the employees are without confidence themselves, due to the insecurity of their positions? How can the employees maintain this "therapeutic" mien under the strain of fatigue due to excessive hours and work load?

We now come to the most pertinent point which Doctor Bachmeyer's committee has raised. They contend that a principal difference exists between the voluntary hospitals and industrial and commercial organizations because of the nonprofit character of the former.

We accept this as correct. We doubt, however, that this affects employees in a qualitative manner. To prove this, we must define employer, employee and their relationship.

An employer is an individual, group or corporation, owning a certain type and size of means of production. The owner's representative may be, and usually is, an administrator or a staff of administrators.

An employee is an individual who has certain abilities and faculties which can be put to use only through the means of production. When thus used, he gets a livelihood. Their re-

lationship is obviously one of mutual dependence.

In both camps there exist interests, common to either group collectively and opposed to the other. The employers and their representatives will try to receive a maximum of labor for a minimum of compensation; the employees attempt to gain a maximum of livelihood for a minimum of labor. Either side is motivated by material interests. The pressure that the employer's group can exert on the employee is based on the latter's dependence on his pay check and is expressed in the threat of dismissal. The employee's weapon against this is collective action.

Returning to the hospital, we apparently have a situation which is favorable for its employees. The hospital and any other nonprofit organization has no material reason to exploit its employees because no profit interest drives it to accumulate great wealth. Presumably, therefore, it will not try to receive the utmost of service for a minimum of compensation.

How then are we to explain that actually the average hospital employee receives even less of an equivalent for his labor than the average industrial worker? Since his interests are similar to those of all workers, namely, increasing his standard of living and reducing the amount of his labor, he should receive more than other employees, because, theoretically, he finds no resistance from his nonprofit employer.

Why Salaries Are Low

We are quite aware of Doctor Bachmeyer's answer to this problem. Just because of its nonprofit character, the voluntary hospital is not able to pay its employees as much as an organization can which cashes in on huge profits. This is so because the hospital serves the whole of the community.

We have a question now for which we fail to find an adequate answer: Why should the hospital worker contribute so much more, proportionately, to the general welfare than the rest of the community? Granting that many hospitals provide much free service and granting also that no hospital can exist if its expenses continue to exceed its total income, why should so large a share of this burden fall on the backs of hospital workers?

We are contributing a great deal by the type of work that we are doing. We are not willing to have a still greater contribution exacted from us in disagreeable working conditions and small pay.

However, we will see to it that this apparent docility is not abused through small wages, poor food, insufficient vacations and medical attention, and on top of all—paternalism. Our weapon against all this is unioniza-



C O - O R D I N A T I O N

When the success of a plan depends upon its perfect execution there must be strict co-ordination between the individuals involved. No program of treatment can relieve the incidence of constipation unless the patient is willing to co-ordinate his efforts with those of the physician. That is why so many doctors

prescribe Petrolagar for their patients. Its pleasant taste and gentle consistent action are acceptable to the patient as well as to the physician Five types of Petrolagar provide a choice of medication to suit the individual case Samples on request. Petrolagar Laboratories, Inc. • Chicago, Ill.



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tion. Why were we not given the improvements which were conceded of late before the growth of unions? We have learned from the past that we have to fight for the improvement of our standard of living, and we will not forget this experience in the future.

We now come to a point which is as important to us as to our employers, namely, the mode of procedure.

(1) We are for arbitration.
(2) We are fundamentally opposed to any strike in a hospital.

(3) Only when we are met with a callous disregard of the employees' rights and an out and out refusal to negotiate or arbitrate will we even consider a strike. We do not believe it will ever be necessary to call a strike, but if it should be necessary, strike plans will be analyzed by competent medical men and hospital experts in order to avoid involving anyone innocent of our controversy, particularly patients.

(4) In this spirit of service to the patient, we are ready to sacrifice our potent weapon, the strike, in favor of arbitration even to the extent of contractual negotiations. With the realization that arbitration will take place after any strike, anyway, we are in full agreement with Doctor Bachmeyer.

Strike to Be Last Resort

The strike is wholly unnecessary procedure if we are met with any degree of cooperation. We much prefer to complete our negotiations without such an effort on our part as the strike. But there are certain indications that appreciable gains will not be made without a struggle.

In this struggle, it must be realized, our opponents are much better equipped than we are. They employ experts, distribute pamphlets, and finally hold over our heads the sword of Damocles—the threat of dismissal.

In spite of this our organization has experienced a rapid growth, proportionally equaled in few industries. This, more clearly than anything else, demonstrates our poor working conditions.

We feel our demands to be just. The most important ones are:

1. Recognition of our union. We demand collective bargaining because we meet the collective force of the hospital administration.

2. Minimum wages of \$75 per month with proper deductions for meals or full maintenance. Where hospitals already meet this, we ask a 20 per cent increase in those wages below \$100 a month and a 10 per cent increase in those wages above \$100 a month. The rise in the cost of living has been considerable while our wages have remained at the same level, a level at which it was hardly possible to exist, before this sharp increase.

3. A 44-hour week. At a time when other industries have already recognized a 35-hour week, we are at a loss to understand how a health institution can resist this demand.

4. Two weeks' vacation with pay. It should not be up to us to explain to a medical institution that this will increase our efficiency and preserve our energy.

The union is here to stay. It is up to the hospital management to show their sincerity in dealing with us and to make the hospital a better place for us, for themselves and for the patient.

LOU BROOKS, Acting President
JOHN G. BROWN,* Member
United Hospital Workers,
Chicago, Ill.

*Since this person is now employed in a hospital the foregoing name is fictitious.—Ed.

Hide and Seek "Flexible Plan"

Sirs:

At the Atlantic City convention, time prevented thorough analysis and the attendant demolition of the house of cards erected by the chairman of the committee on construction. As the brief comments that were permitted blew down but a few of the cards, may I add a puff or two to the remaining ones?

The major premise, that "hospital capacities have been excessive," is not now correct and never was correct, broadly speaking, even at the time of the lowest bed occupancy. All that can be said is that the number of beds available was in excess of the communities' ability to support them, either by taxes, gifts or patient fees. The report itself demonstrates this in these words: "wards were overcrowded and private rooms stood empty."

The broad statement made by the chairman, that "as we have planned in the past" a hospital of 127 beds would be erected to care for an average of 85 patients, betrays a singular lack of experience and observation.

To say that one of our modern hospitals was deliberately planned for an expected average occupancy of only 67 per cent is to imply that the hospital trustees were blind to their trust and the administrators imbeciles in thus wasting philanthropic funds. That they were occupied at only 67 per cent was not because of "planning" but because of factors entirely beyond their control.

The panacea suggested, that of small wards and elimination of rigid boundary lines for the various specialties, is entirely correct. But both of these have been clearly understood by hospital administrators for twenty years and longer. These principles are now so well established that they are perhaps too indiscriminately accepted.

The practicability of the suggestion to move the patient is doubtful, to say the least. The patient is hardly a shuttle to be sent spinning back and forth along the hospital corridor as his temperature changes.

Then the chairman outstrips the great magician Thurston. He can make beds appear and disappear at will, and if he chooses not to count them, they aren't there. It's so simple to follow this "flexible plan." No new building is needed. Let all hospitals of the country remove every fourth bed to the storeroom and, immediately, it ceases to exist, overbuilding ends and the hospitals happily report from 90 to 95 per cent average occupancy! As a four-bed ward, it contains 96.88 square feet per bed, only 20 per cent over-size to those who are accustomed to the 80 square feet standard. That the chairman calls economical planning! To be sure, it may be used for five beds when needed, but the area is then a bit under the standard—75.5 square feet per bed. If that is approved, why provide 96.88 square feet for four beds; if it is, why not build the four-bed wards that size in the first place?

If four of these over-size wards were built, the maximum capacity would be twenty; if five of the 75.5 square foot wards were built the capacity and the area would be practically the same. The cost would be almost the same and the operating costs identical. If the hospital needed only sixteen of the twenty beds in the smaller units, then a key might be turned on one room. In the "flexible plan," the bed would be torn down and sent

to the nether depths to be returned when needed.

The chairman supposes that if the administrator locks the door on a room he must count the beds as unoccupied, but if he parks these beds in the storeroom temporarily, he need not count them at all! A method that would be far less laborious would be for the administrator to wear Cagliostro spectacles so he could not see or count those beds that were unoccupied. He could then always report 100 per cent occupancy with corresponding effects on the "savings in capital investment," "fixed charges" and "readiness to serve costs."

Then the chairman adds the "staggered wing" plan. Perhaps it is well named if, as we must assume, it is a part of the economy program. The staggered wings stagger so much that there is a loss of about 1,800 square feet of area on each floor at the crossings of the corridors. That is 5½ per cent of the total floor area, a mere trifle, of course, to one who is willing to oversize his wards by 20 per cent.

The comparisons between the data for this "flexible plan" and that for the Springfield Hospital are interesting, but questionable. If the private rooms can be used for two beds, and the solariums and airing balconies for patients in the "flexible plan," why can't they be similarly used in the 1929 plan? The chairman carefully refrains from figuring the "maximum" or emergency capacity in the 1929 plan. How would such data compare with that of the "flexible plan"?

On behalf of faithful trustees and capable executives who are directly responsible for what the chairman fervidly refers to as "the shocking waste of capital funds" and "the general overproduction of beds," I hope that I have given a helpful analysis of this new "panacea" offered the American Hospital Association.

CARL A. ERIKSON.

Chicago, Ill.

A copy of the foregoing letter was sent to Mr. Neergaard, but since he is now abroad his reply has been delayed and will appear in a future issue.—Ed.

Names in the News

(Continued from page 116)

Department Heads

MARY M. NEWTON, R.R.L., is installing a medical records system at the Methodist Hospital of Central Illinois, Peoria. Miss Newton has been in this position since September 1.

LEONORA PERRY, who has been a staff member of the journal, *Surgery, Gynecology and Obstetrics*, for a number of years, has succeeded MARGUERITE SIMMONS as librarian at the George W. Green Medical Library of Ravenswood Hospital, Chicago.

JANETTE M. SELFRIDGE, R.N., is the new principal of the school of nursing and superintendent of nurses at Memorial Hospital, Albany, N. Y., succeeding MRS. IONE SLOUGH.

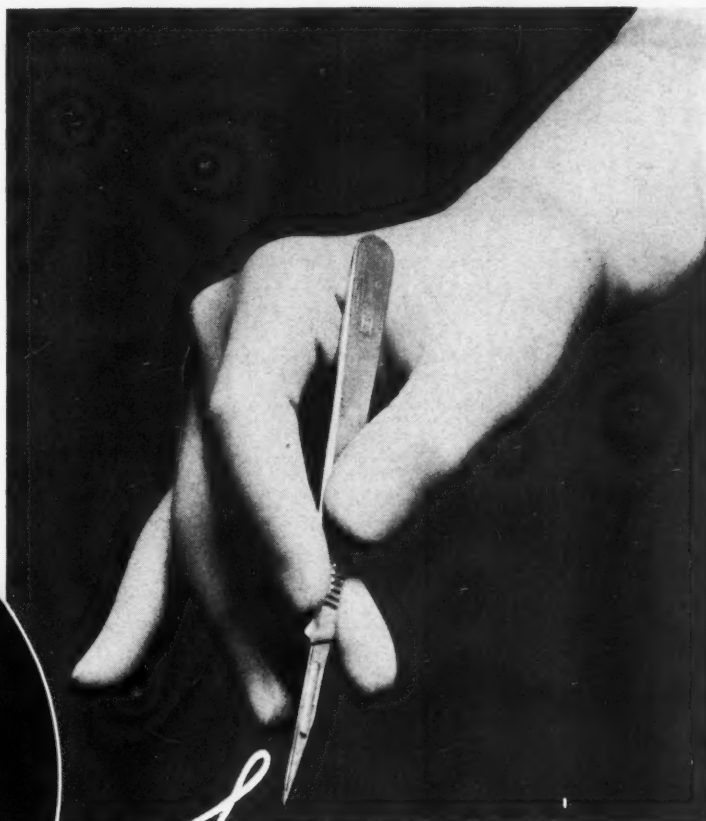
LOUISE BAKER has been appointed superintendent of nurses and head of the Knapp College of Nursing at the Cottage Hospital, Santa Barbara, Calif.

LUCILE NICHOLSON will succeed GOLDEN WILLIAMS as director of nurses at Knoxville General Hospital, Knoxville, Tenn.

MARY REID DONALD, for sixteen years superintendent of nurses at Albany Hospital, Albany, N. Y., has retired. She is credited with bringing the hospital to an A-1 rating and to the rank of seventh best.

AGNES RICHLING is the new dietitian at the Norfolk State Hospital, Norfolk, Neb.

Richard Wagner, most famous of German composers. Born in Leipzig, Germany, May 22, 1813, of a theatrical family. Died in Venice, Italy, on February 13, 1883.



Flexibility

Only through **FLEXIBILITY** and **SENSITIVENESS OF TOUCH** could the great genius of Richard Wagner find true expression . . . ease of motion that left the great master's hands free from strain after hours of work. Such are the advantages of Wiltex white and Wilco brown curved finger latex gloves—freedom through controlled fit, plus clarity of touch through the use of genuine liquid latex . . . with **GREATER STRENGTH** and **LONGER LIFE** than was ever thought possible in so thin a glove. . . .

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LITERATURE in ABSTRACT • • •

Conducted by E. M. Bluestone, M.D. and Joe R. Clemmons, M.D.

Sanatorium Schools?

The prophecy that early diagnosis and improved treatment of tuberculosis will in a few years so change the set-up of tuberculosis sanatoriums that they will become schools under medical control, rather than hospitals, is one of the conclusions suggested by the results of a recent experiment in rehabilitation at the Hamilton County Tuberculosis Sanatorium at Cincinnati.*

This project, undertaken jointly by the National Tuberculosis Association and the County Sanatorium, combined a test of psychological-aptitude-procedures with a reorganization of the lay services of the hospital. A series of highly specialized tests was given to more than 25 per cent of the patients in this hospital. These were compared with indications supplied by interviews, educational and work records. The urge to acquire marketable assets emerged distinctly from results thus obtained, and an educational program was devised to take care of different types of individual needs, with a special view to the physical limitations of "arrested" tuberculous patients and the particular demands of the Cincinnati labor market.

Secretarial studies, woodwork and domestic science for housewives were the principal activities selected; music and graphic arts also were found of great use in the reorientation of those psychologically affected by the depressing nature of their disease.

The conclusions arrived at are admittedly tentative, in view of the short period of experimentation, but the following facts seem to be quite definitely established:

1. The cooperation of the physician with the psychologist, teacher and social worker is essential.
2. The application of scientific tests is advisable, however wisely the patient may have been otherwise observed.
3. A continual contact with industrial conditions and the state employment bureau will assure a correct perspective of the current situation in the field of labor.

*Hudson, Holland: Cincinnati's Program of Rehabilitation, Occupations. Pp. 598-604. (April) 1937. Abstracted by Celia M. Pearson.

Simple Oxygen Analyzer

The apparatus described* is an inexpensive, easily constructed oxygen analyzer intended for use with the oxygen tent. The technical details of its construction are best under-

stood by referring to the original article. In principle it is a simple absorption chamber and reservoir utilizing a mixture of one part concentrated (28 per cent) ammonia in two parts of saturated ammonium chloride. About 100 c.c. of this mixture is capable of testing 300 samples of gas before renewal of the solution.

The accuracy is about $\frac{\text{plus}}{\text{minus}} 2$ per cent—sufficient for clinical purposes. The determination itself is simple and can be taught to the average ward attendant in about one minute.

The analyzer is of particular value to the hospital of moderate size in which the laboratory service does not include gas analysis.

Reprints of this article may be had for the asking, on application to the author.

*Hoechstetter, S. S., M.D.: An Oxygen Analyzer for Use in Oxygen Tent Therapy. The Journal of Laboratory and Clinical Medicine. St. Louis 22: 1062 (July) 1937. Abstracted by Leonard Tarr, M.D.

Kitchen Fire Hazards

Besides defective electrical or heating furnace installation, the majority of fire hazards in a restaurant are confined to the kitchen. Smoking and careless disposal of matches ranks second only to greasy stoves among major causes of restaurant fires. Defective equipment, poor arrangement and faulty use of stoves are listed as the third major cause.*

Horizontal and vertical openings to other parts of the building should have protection at least equal to the fire retardant classification of walls or floors in which the necessary openings are made.

It is recommended that oil vapors be vented to the outside of the building. Hoods over cooking equipment should be constructed of No. 18 gauge steel and all seams tightly riveted. Minimum clearance to combustible material should be at least 18 inches at the sides and rear and 48 inches above and in front of heating devices for complete safety.

Floor protection underneath heating devices is important. Two courses of 4-inch hollow tile crossed, with boiler iron on top and one-fourth-inch asbestos board covered with sheet metal between the tile and floor, are the best protection that can be afforded in all types of kitchens.

*John D. Phelan: Fighting Fire Hazards, Am. Rest. Mag. 44 (Aug.) 1937. Abstracted by Rosalyn Siegel.

Dietetics in Retrospect

It is difficult to draw the line between the old and the new.* All Harvard historians testify that the college would not be celebrating its tercentenary if Henry Dunster had failed to rescue the school from oblivion by showing the cook how to prepare pudding that was both hasty and tasty and the brewer how to make potable ale. He centered his attention upon food and the college flourished. Florence Nightingale directed her attention to the food problem of the hospital in Scutari (1854). Early records show again and again the trials, and the joys of the administrative problem of feeding people in large groups.

Coming closer to the present time, meetings held at Lake Placid, N. Y., have considered the needs of the institution household. The seventh Lake Placid Conference held in 1905 reported the creation of a new position—that of director of residence halls. The job was filled by one trained in domestic science. At the eighth conference the college seemed to have been a subject for considerable study. A report quoted Mrs. Ellen H. Richards as saying, "Every higher school still clings to the pre-evolution idea that no matter what a student eats, a book and midnight oil will make a scholar of him." Thanks to the efforts of many people, today colleges are considering what the student eats and where he sleeps. In the proceedings of the eighth conference the term "institution manager" appears for the first time.

During the years institution administrators have been pooling information and organizing to help meet the needs of the day's work in the college, the school lunchroom and the hospital. On the college campus the dietitian controls the dormitory food service and student cooperative unions. In the public school the lunchroom is operated by the school board rather than by a concessionaire. The hospital dietitian has her own budget and her meals are nutritionally adequate and adapted to the needs of the patient, even in departments that are operating on low budgets.

In the field of food administration facts are being assembled from consumption and labor studies about the administration of large quantity food units and the yields of average wholesale packages.

A new venture in the professional association is the approval of student dietitian courses for students interested primarily in food administration. The American Dietetic Association now approves three such courses planned to give the recent graduate actual experience in various phases of the administrator's work.

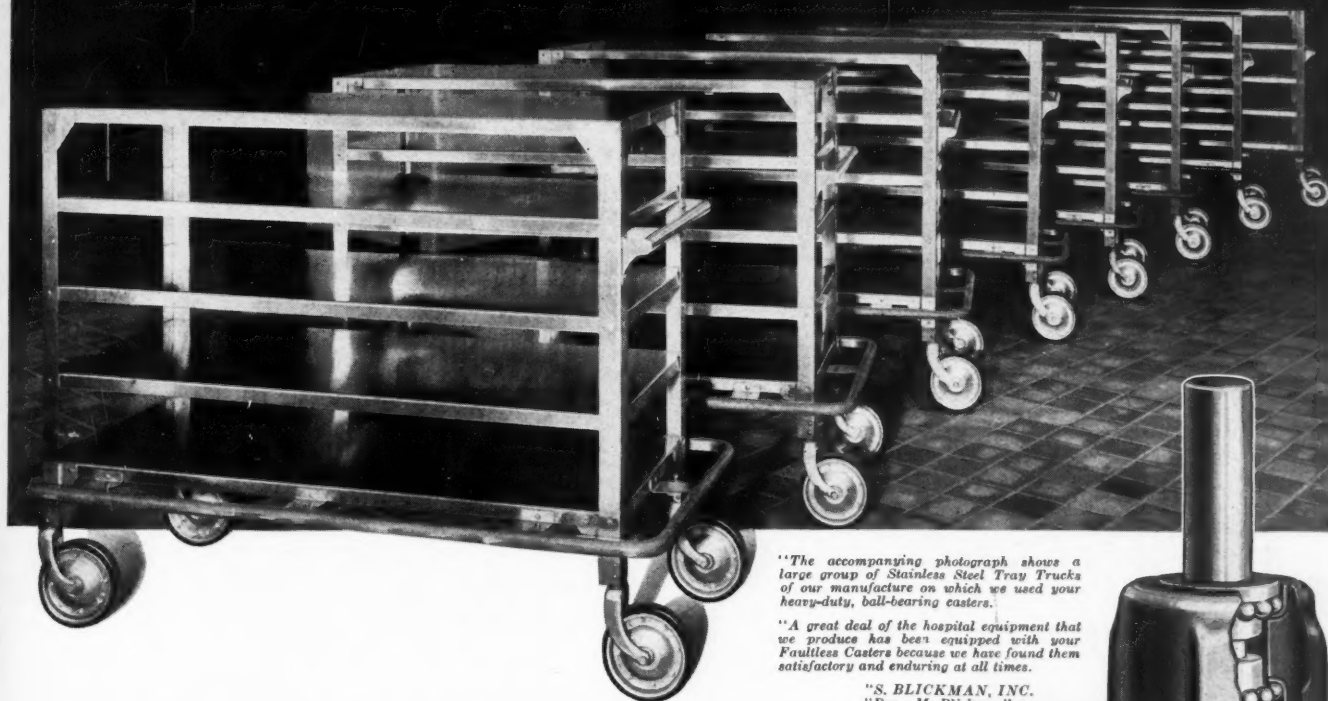
*Tracy, Anna M.: The Old and New in Administration, Journal of the American Dietetic Association (Sept.) 1937. Abstracted by Amber Irene Wolf.

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Combating Syphilis

Any solution to the plan of combating syphilis must take cognizance of the special problem found in towns and cities. The plan* as devised for New York City is believed to be sound and practical. Although 1,000 new cases of syphilis are reported each week to the department of health in New York City, this is probably about one-seventh of the actual rate.

The best hope of combating this disease as a public menace is to make it noninfectious through early treatment. This has been proved in countries such as Denmark, Sweden and Great Britain. Through cooperation of 14,000 private physicians the desired result can be obtained. Several practical aids have been devised toward that end.

1. Diagnostic services: During 1936, 345,000 specimens were tested at the department of health without charge. At seventeen diagnostic centers throughout the city, blood can be taken and dark-field examinations done for indigent patients on the recommendation of their physician. Reports are sent directly to the physician.

2. Treatment services: Using special funds, the department of health will supply to the physician all drugs necessary to treat a particular case for one year. It is assumed that the patient is unable to pay the physician his full fee, but otherwise no attempt is made to regulate any payment by the patient to the doctor. At present only early cases, congenital lues and pregnant patients are being thus handled. With more funds available this will be extended to other luetics. On request, a nurse is supplied who will follow up any lapsed cases in treatment.

3. Epidemiologic service: A staff of trained physician investigators is available in tracing contacts and sources of infection in the cases reported by the family doctor. Action is taken only on his request. With this plan, 25 per cent of the sources of infection have been brought under medical care.

4. Educational activities: Pamphlets of information in English and foreign languages are available for distribution to the patients suffering from venereal disease. The health department also cooperates in making available postgraduate instruction to physicians.

5. Reporting of syphilis: Confidential reports by the patient's initials are requested of physicians. Free mailing facilities are made available.

In addition to the foregoing services to private physicians, the hospital administrator will be interested to know that some fifty clinics in voluntary hospitals are aided by the department of health with drugs for treatment and follow-up services on lapsed cases.

The department of health is interested in syphilis as a communicable disease. It works through and supports other agencies. It also maintains ten treatment centers for the very poor and indigent. Through increased budgetary allotments and WPA assistance, the work has been expanded along the lines outlined above. The number of reported cases has increased 50 per cent from 1932 to 1936.

*Clarke, Charles Walter, M.D.: A Typical City Program for Combating Syphilis and Gonorrhea. J. A. M. A. 109: 1021 (Sept. 25) 1937. Abstracted by Leonard Tarr, M. D.

Employees' Unions

"The growth of unionism as a new force in the establishment of working relationships is not yet appreciated by many hospital executives."* If hospital administrators face the fact that there are likely to be other hospital strikes similar to those in New York last winter, their best chance to avoid labor troubles lies in immediate and careful study of labor relations.

Until such a time as hospital unions can arrive at a definite policy and adapt their aggressive tactics to the functions and problems of hospitals, there will be need of patience and tolerance on both sides.

Despite its small membership the recently formed Hospital Employees Union is a real force. Indicative of the changing viewpoint is the fact that at the Brooklyn Jewish Hospital, where the longest strike was waged, out of fifty-eight workers arrested not one served a jail term. Unions are willing to obtain sympathy through publicizing wage and living conditions but they also are quite aware of the force of unfavorable public opinion when aroused by a strike cutting off services essential to life.

Results of hospital strikes have not been as disastrous as newspaper and radio publicity would lead one to believe. When certain minimum services are maintained so that patients' lives are not endangered, the hospital can get along without a part of the maintenance staff for a day or two, since professional employees are able to supply some of the services.

Factors contributing to the unrest and dissatisfaction of workers in hospitals include a low wage level, resulting in a high labor turnover, inadequate policies of personnel administration and lack of social security. A survey conducted by the union showed that some employees are paid as little as \$25 a month, with maintenance. The New York Department of Hospitals has set a minimum of \$35 a month, with maintenance, for its municipal institutions.

It is true that the hospital is not an ordinary business enterprise and should not deal with its employees in the manner of a factory owner. On

the other hand, hospital workers do not enjoy some of the privileges of factory workers, namely, social security, fewer wage cuts and uniform working hours. For all of these reasons hospitals cannot continue indefinitely to claim exemptions from collective bargaining. Balanced against those authorities who wish to destroy or prevent unionism with generous personnel policies are the demands of the union: a minimum wage of \$100 a month, a maximum eight-consecutive-hour day, a forty-eight-hour week, abolition of the living-in system and four weeks' vacation with pay.

Although hospital workers have organized primarily to promote their own interests, their union activities have speeded up the clarification of the social function of the hospital, its public relations and its responsibilities.

*Gambis, John S.: Hospitals and the Unions, Survey Graphic, August, 1937.

Modernizing Laundries

For the last two years executives of Hotels Statler Company, Inc., with cooperation from authorities of a laundry machinery company, have reduced laundry costs in their hotels through modernization, repair and rearrangement of equipment.*

In the washing department of the Cleveland Statler, where approximately \$68,000 was spent, nondump type Y-pocket washers of stainless metal were installed to replace old type cascade washers with brass cylinders.

Another type washer, replacing an old solid-head washer, was installed for washing fabrics and blankets. This machine was equipped with special temperature regulating valves and with a two-speed motor, permitting it to be operated at slow speed for blanket washing.

Great saving was effected in the wear on linens through the use of Y-pocket washers, permitting the contents of each division of the cylinder to be slid out directly into the portable extractor cylinders.

Installation of an overhead monorail system and electric hoists with a capacity of 1,000 pounds each for handling flatwork between the washing department, extractors, flatwork ironers and drying tumblers saved 30 per cent in the number of labor hours required in the washing and extracting departments and in handling of linen inside the laundry, in addition to speeding up production and saving in wear on the linens.

With an estimated saving of \$8,000 to \$10,000 annually over the cost of having work done by outside plants, the operation of laundries can be conducted on a highly profitable basis.

*Unsigned, Modernization Cuts Statler Laundry Costs, Hotel Mgmt. (Aug.) 1937. Abstracted by Ida Wides.

ONLY RELAX GIVES PATIENTS BED PAN COMFORT

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Pat. No.
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Scientifically designed, the modern Relax bed pan provides indispensable new benefits praised by doctors, nurses and patients alike. Its rounded bottom permits the wide body-conforming seat area to sink to mattress level. Patients can rock or shift to an unstrained position. Even in cases of fractured pelvis, fractured hip, T.B. spine, and acute arthritis, it allows comfortable evacuation. Beneficial comfort replaces misery. Patients no longer contest the use of a bed pan . . . Nurses and orderlies like the ease of pan placement — especially with heavy patients. No hard lifting is required. The rounded bottom design of the Relax permits an easy roll-on action. Possibility of spillage has also been minimized . . . To hospitals that have not seen or tried the Relax, a sample is offered free.

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"It is wonderful, so easy to place, and the patients say it is so comfortable."

"Find it is very satisfactory and such a decided improvement upon the old style bed pans."

"Both patients and nurses alike are praising the Relax. We are buying only Relax for replacements."

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"I have been in bed a year from arthritis, so appreciate having one so fine and comfortable." (From a patient previously unable to use any style of bed pan).

"The Relax marks a new note for comfort and facility for both patients and attendants."

*Names upon request

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The new "Longwood" hot oil instrument sterilizer, we are assured, provides a sure and safe method for sterilizing instruments without rusting or damaging. Hot oil is said to protect delicate instruments while scissors, knives, scalpels and needles retain their original sharpness. The hot oil, automatically held at 302° F. (150° C.) kills bacteria, even those strong, persevering anthrax spores, the hardest form of life to destroy, in ten minutes, it is said. Staphylococci, which can't take it, wilt under 150° C. in fifteen seconds.

The sterilizer is insulated to conserve the heat and to prevent odors from escaping. The heating elements are especially designed for oil and the thermostat is constructed to maintain the sterilizing temperature constantly without dangerous variations up or down.

This unit is available in two models, floorstand or table, according to the space requirements.

Liver Therapy Without Liver

In the early days of this country's history the sturdy pioneers, confronted with the necessity for transporting food over long distances, resorted to the expedient of drying and preserving their meat by exposure to sun and wind. The result, "jerked" meat, was tough and unpalatable, but nourishing.

From this fairly simple process, modern scientists have evolved the idea of concentrating medicinal substances extracted from animal products, though by a much more involved and complex method than mere dehydration. Among these medicinal products is liver (the palatability of which, in any form, is open to question) which has been reduced to a mere shadow of its former self, physically speaking, but retains all its old wallop in the concentrated form. Recently a new liver product has been marketed by Eli Lilly and Company, Indianapolis, which it regards as another advancement in the conquest of anemia. "Reticulogen" (parenteral liver extract with vitamin B) is of such concentration that the injection of 0.5 cc. has a hematopoietic effect which is said to be comparable to that produced by the ingestion of from 3,000 to 4,500 grams of fresh liver.

Coffee in a Hurry

Seventy-five cups of coffee a day—that's the average consumption (or so his press agent says) of a well-known radio artist. Query: what does his wife, who has to prepare it, do in her spare time? One would think the lady couldn't look a coffee pot in the eye. If she ever reaches that stage, we would recommend that she consider the proposition of the Coffee Products Corporation, 601 West 26th Street, New York City. Its new products, Red-E-



HOSPITALS DO IT, TOO!

Dirt-catching corners in modern hospitals have been replaced with corners that are rounded and easy-to-clean. Hygeia had the same idea when they eliminated corners and crevices in their nursing bottles and nipples. Look at these features that make cleaning easy and safe:

NIPPLE—is easily inverted for a thorough cleaning. Patented tab guards against fingers touching sterilized surface. Available in 3 shapes of teats... black, red or translucent rubber.

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● Not only the two trays, but also the ENTIRE REMAINING STRUCTURE of the table is made of super-sanitary, easily-cleaned, permanently beautiful Stainless Steel. It hasn't a single drop of paint or enamel anywhere on it, nor a square inch of plated surface. In consequence, it cannot become chipped or marred, and is completely unaffected by constant washing or cleaning.

● This, and numerous other items of Operating Room Furniture made entirely of hard, enduring Stainless Steel, are illustrated in Bulletin No. 10 O R. Write for it.

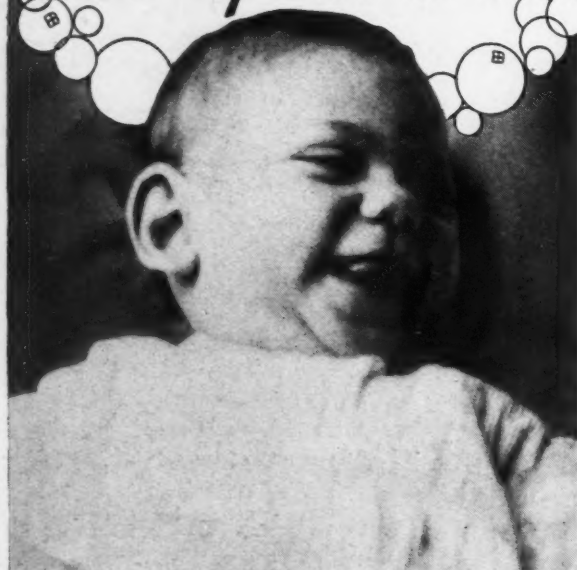
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IF there is one word that truly describes the baby's condition after the Baby-San bath, that word is—COMFORTABLE.

How could it be otherwise? This purest liquid castile soap is made with the finest grade of edible olive oil. It contains no fillers—no excess alkali—no free fatty acids. Hence, Baby-San's rich, soothing lather brings only comfort to the baby's skin.

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• BABY-SAN •

AMERICA'S FAVORITE BABY SOAP

Coffee and the dispensing device that accompanies it, Red-E-Meter, were practically made for such situations. Red-E-Coffee is a concentrated coffee which, we are informed, retains the volatile aromatics contained in the bean. It is concentrated to a strength which requires only a teaspoonful in a cup of hot water.

The Red-E-Meter dispensing device is a clever item which is not sold but is lent, under contract, to purchasers of the coffee. The manipulation of the dispenser is simple and convenient.

The cap is removed from the coffee bottle, an aluminum shield is slipped over the bottle so that the neck protrudes through the hole in the top of the shield, and the meter is screwed on to the neck of the bottle. The dispenser is inverted in such a manner that the spout is in proper pouring position, and then brought back into an upright position.

Then when the dispenser is again inverted it will deliver one teaspoonful, no more and no less, of the coffee. Sounds like an idea for that between-meals cup of coffee.

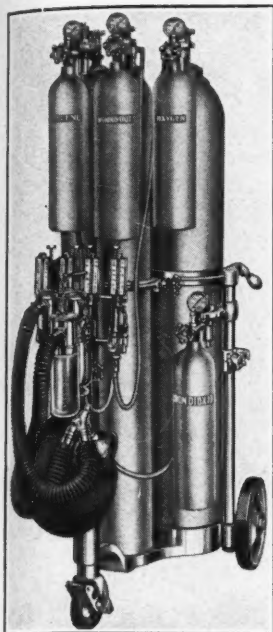
Dealing It Out

Alcohol dispensers are looked down upon by the more respected members of society. The human ones, that is; but we can mention, Without the slightest hint of impropriety, A mechanical dispenser that should 'rouse The interest of physicians and all such, Who, when they wash the germs away in alcohol, Most definitely do not want to get too much; Who are likely to say far worse things than "Fie!" When a sudden shower hits them in the eye. The Vestal Chemical Laboratories, Inc., (Their home is way down in St. Louis, Mo.), Have been making things like this for quite a while So we allow they surely ought to know. And when they state that this, their newest item, Has as many benefits as, count 'em, eight, 'Twould seem that it should be worth your while To take some time out to investigate. Continuous spray, which covers hands and arms At a slight, not to say fairylike, foot pressure, As well as standing straight instead of crouching Like a chimpanzee, makes using it a pleasure. The Vestal Company, we're very sure, Will be exceedingly happy to enlarge Upon this very limited discussion. And there'll be no obligation and no charge.

Stainless Forever

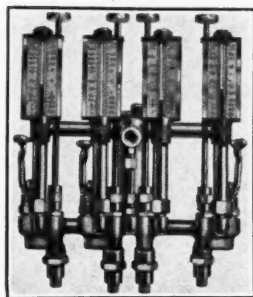
Cause for pondering was given S. Blickman, Inc., of Weehawken, N. J., by the fact that, hitherto, operating and examining tables were constructed with stainless steel tops and enameled iron framework. Why not make the whole table of stainless steel, they mused. They set to work to solve the problem and produced a completely stainless steel examining and operating table, meanwhile discovering additional advantages. Therefore, Blickman Inc. feel that word should be passed along that they are willing to vouch for the durability, sterility and freedom from the necessity of frequent repairs of stainless steel in the framework as well as in the tops of operating tables.

Several models are available for all types of work. There is the Baxter Model in three sections which can be adjusted from the horizontal plane to a 90° upright position for chair work, or to Trendelenburg and reverse Trendelenburg positions. Other models are made in two or three sections, or of solid construction.



HEIDBRINK GAS APPARATUS

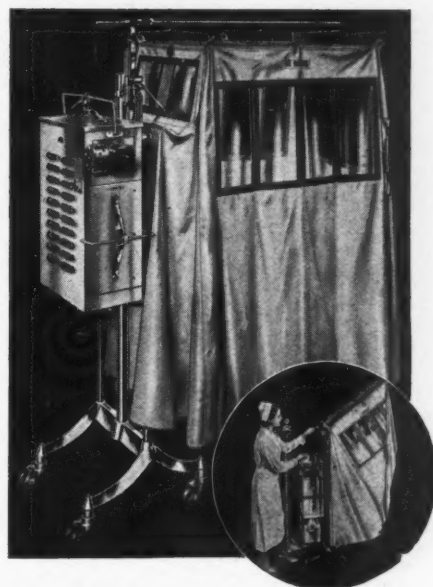
Better results, at greatly reduced cost, is a Heidbrink contribution to Anesthesia. The unequalled performance of the Kinet-O-Meter and the accuracy and simplicity of the mechanical features instill confidence in the operator and greatly assist in procuring desired results.



FLOWMETERS

The simple Dry-Float Flowmeters of the Kinet-O-Meter control, measure, register and deliver each gas independently and accurately.

**DESCRIPTIVE LITERATURE
FREE UPON REQUEST**



OXYGEN TENTS

HEIDBRINK Oxygen Tents control all the elements so essential to the patient's welfare. They operate almost silently, are accurate in their deliveries, dependable in their functioning, and present no mechanical or handling problems.

HI-CO

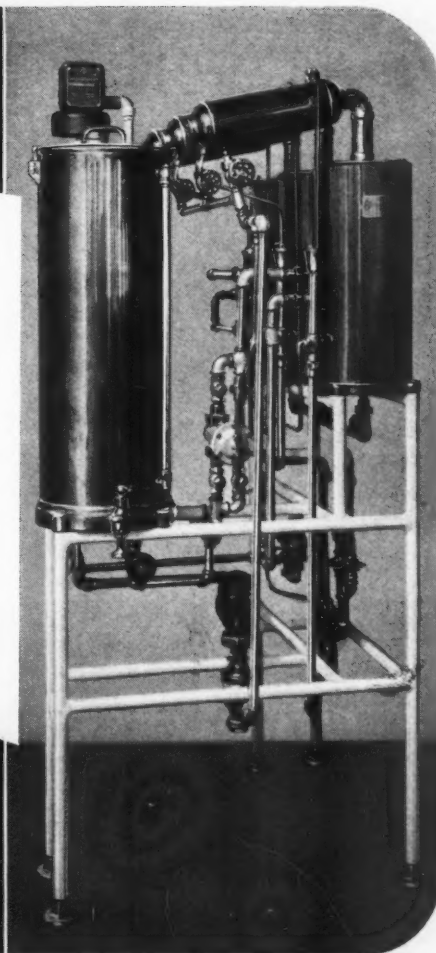
THE HEIDBRINK COMPANY
MINNEAPOLIS MINNESOTA

FOR YOUR STEADY FLOW OF SAFETY use Barnstead Water Stills

You never know when you need pure, fresh distilled water. A call might come in any instant. And for that reason it is wise to have a Barnstead Water Still as part of your equipment. Automatically—twenty-four hours a day—Barnstead Water Stills give you an unfailing supply of pure, danger-proof water—always ready, always fresh, always safe—no matter how much you use.

Thousands of hospitals—the world over—use the Barnstead. For it's the easiest, most economical, and surest way to get the purest water. There's no work to it, no waste, and its distillate is free from pyrogens, including bacterial toxins.

Furthermore, there is always a Barnstead Water Still that exactly suits your needs. For Barnstead makes the widest range of hospital stills. Single, double, triple stills. Steam, gas and electrically operated stills. Stills with outputs ranging from ½ gallons per hour up to 500 gallons per hour. Stills with any type of mounting. Send for our new complete catalog.



Barnstead
STILL & STERILIZER CO. Inc.

31 LANESVILLE TERRACE, FOREST HILLS, BOSTON, MASSACHUSETTS



*Give your patients this
new refreshing* nourishment*



***(REFRESHING TO BUDGETS, TOO)**

IT'S welcome news to the dietitian when a delicious drink like Bireley's Orangeade fits into the budget without crowding—in fact with room to spare! Bireley's Orangeade is welcome news to patients, too. Here's the most popular fruit-juice beverage in the country, distributed daily by over 3000 dairies like fresh milk, made wholly from real orange juice, sugar, water, and a dash of lemon-acid for "nip." Your milkman will gladly give you the analysis (and budget-balancing cost) when he brings a free quart to sample. Just use the coupon.

BIRELEY'S Orangeade

(NON-CARBONATED)



Open Only to Hospital Dietitians, Purchasing Agents, or Administrators

BIRELEY'S, INC., Hollywood, California

Gentlemen: Please deliver a free quart of Bireley's Orangeade.

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Paging New Literature

Song Without Words—If the old axiom is true that one picture is worth a thousand words, to which we heartily subscribe, the new picture portfolio of the Goodyear Tire and Rubber Company, Inc., Akron, Ohio, translated into prose would sound like a senate filibuster. There are just ninety-five stunning photographs showing installations of practically every type of rubber flooring, both the rubber tile and roll varieties. The only copy in the book is confined to a few well-chosen words in the foreword as to the advantages of rubber flooring: durability, cleanliness, stain and fire-resistance, quiet and beauty. As for the pictures—read 'em and weep. The portfolio, bound in heavy crimson stock, is at the disposal of those who are interested in rubber flooring.

Shooting the Rivetless Chutes—How many people, do you suppose, are ever tempted to play shoot the chutes when they see the open door of a slick, shiny clothes chute? It looks just as inviting to us as the old sliding board ever did and we may yet give way to our childish impulses.

No sliding board was ever smoother or more free from exposed rivets or bolts, it is claimed by Haslett Chute and Conveyor Company, Oaks, Pa., than the inside of the aluminum clothes chute which is described in a brochure which just came our way. These chutes are constructed of aluminum, which presents a smooth surface that will not chip or crack. Sanitation is assured by a flushing spray which flushes the interior of the chute.

Cans That Can Take It—Garbage cans and the uses thereof may not make edifying drawing-room conversation but their place in our scheme of things is not to be denied. Therefore, the contention of Witt Cornice Company, Cincinnati, Ohio, that considerable attention should be paid to quality in garbage cans will not start any arguments.

The quality of Witt cans for garbage, ashes, oily waste and food storage is explained and illustrated in detail in a thirty-six-page booklet which they will be glad to send on request.

For Your Convenience—When bigger and better catalogues are brought out some people still won't know how to go about using them. But it would take a low order of intelligence, indeed, not to be able to find what you want quickly and easily in Catalogue No. 165, the latest and handsomest effort of Sharp and Smith, hospital division of the A. S. Aloe Company, St. Louis. In the first place, there's practically everything that a hospital administrator's heart could wish for, and in the second place, the book is departmented, itemized and indexed within an inch of its life. As far as we can see, all the items mentioned are illustrated, many of them in natural colors.

At the end of the catalogue appear check lists of the fundamental equipment and supply needs of a hospital.

Joy for the Housekeeper—It does seem that the subject of cleanliness in hospitals must have been exhausted as a topic of conversation long ago. But, no—somebody is always popping up to call our attention to a new product or a new catalogue of products for the promotion of cleanliness which he thinks should be called to your attention, via these columns. This time it is the Theo. B. Robertson Products Company, Inc., 700 West Division Street, Chicago, with a new catalogue which it has titled, simply but with great feeling, "Cleanliness." This company does seem to have the situation pretty well in hand, at that, beginning with 20th Century soap, the original product, and including all kinds of cleansers, disinfectants, sanitary supplies, mops and brushes even to Venetian blind dusters.

SAVE



...ON LAUNDRY OPERATING COST

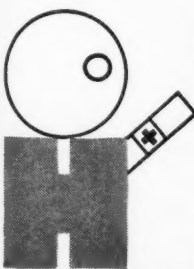
IN A 200-BED HOSPITAL, 15 LBS. PER BED PER DAY, DIRECT AND INDIRECT

—AND HERE'S WHAT HAPPENS

1¢ PER LB. = \$30 SAVING PER DAY

1¢ PER LB. = \$210 SAVING PER WEEK

1¢ PER LB. = \$10,950 SAVING PER YEAR



CALL HOFFMAN FOR A SURVEY OF YOUR LAUNDRY COSTS

Savings like these are frequently realized, without loss of quality, when Hoffman laundry engineers survey the institutional laundry setup.

U.S. HOFFMAN

MACHINERY CORPORATION
105 FOURTH AVENUE NEW YORK, N. Y.

COMPLETE LAUNDRY EQUIPMENT
SERVICE FOR THE INSTITUTION



PATIENTS WEAR OUT THE SHEETS trying to sleep in YOUR HOSPITAL?

WHEN it's time for "lights out" do they toss and turn just *hoping* for sleep? Hundreds of hospitals have solved this problem . . . solved it by giving patients a "nightcap" of hot Cocomalt and milk.

This delicious, drugless, *protective food drink* does more than help induce calm, restful sleep *quickly*. It supplies important food essentials. Iron, for example. Each ounce—enough for one serving of Cocomalt—is fortified with 5 milligrams of effective Iron (biologically tested for assimilation). Leading authorities agree that this is enough Iron to supply $\frac{1}{2}$ of the normal patient's daily nutritional requirement.

Cocomalt is further enriched with .15 gram of Calcium, .16 gram of Phosphorus in each ounce-serving. And, making these food-minerals available to the system there are, in each ounce of Cocomalt, 81 U.S.P. Units of Vitamin D . . . derived from natural oils and biologically tested for potency.

Cocomalt is economical and few patients can resist its creamy, distinctive flavor. On sale, at all grocery and drug stores in $\frac{1}{2}$ -lb., 1-lb. and the economical 5-lb. hospital size purity-sealed cans.

Cocomalt is the registered trade-mark of R. B. Davis Co., Hoboken, N. J.

	1 Ounce of Cocomalt adds	1 Glass of Milk (8 Liquid Ozs.) contains	Result! 1 Glass of Cocomalt and milk contains
*IRON	0.005 GRAM	*TRACE	0.005 GRAM
*VITAMIN D	81 U. S. P. UNITS	*SMALL AMOUNT, VARIABLE	81 U. S. P. UNITS
*CALCIUM	0.15 GRAM	0.24 GRAM	0.39 GRAM
*PHOSPHORUS	0.16 "	0.17 "	0.33 "
PROTEIN	4.00 GRAMS	7.92 GRAMS	11.92 GRAMS
FAT	1.25 "	8.53 "	9.78 "
CARBOHYDRATES	21.50 "	10.97 "	32.47 "

★Normally Iron and Vitamin D are present in Milk in only very small and variable amounts.

†Cocomalt, the protective food drink, is fortified with these amounts of Calcium, Phosphorus, Iron and Vitamin D.

FREE..To Hospital Supply Officers



R. B. Davis Co., Hoboken, N. J., Dept. N-11
Please send the Free Can of Cocomalt you offer

Name _____
Street and Number _____
City _____ State _____

"OUR HOSPITAL HAS BEEN SAVED"

This is the enthusiastic comment of George P. Boor, president of the Maple Avenue Hospital of DuBois, Pa., after a recent successful campaign under the direction of Pierce and Hedrick.

The institution was not only in financial difficulties, but the relation of the hospital to the public was such that contributions of money and supplies had been falling off decidedly. The campaign radically changed the attitude toward the hospital. Other problems of internal management which had troubled the trustees for years were also smoothed out as a result of the campaign.

Mr. Boor enthusiastically commends and recommends the services of Pierce and Hedrick to all hospitals suffering as did the DuBois institution.

The campaign for better community support in this Pennsylvania town is only one of a number of recent successful efforts to interpret hospitals to their communities.

If you have a problem of a similar sort we shall be glad to discuss it with you at your convenience. Such consultation involves no obligation. Would you like to read our publication "Institutional Financing"? It is free on request.

PIERCE and HEDRICK

INCORPORATED

30 Rockefeller Plaza New York

100 N. La Salle St., Chicago — 837 Phelan Bldg.,
San Francisco

BOOKS ON REVIEW

PUBLIC MEDICAL SERVICES, A SURVEY OF TAX-SUPPORTED MEDICAL CARE IN THE UNITED STATES. By Michael M. Davis, Ph.D. Chicago: University of Chicago Press. 1937. Pp. 170. \$1.50.

THE COST OF ADEQUATE MEDICAL CARE. By Samuel Bradbury, M.D. Chicago: University of Chicago Press. 1937. Pp. 86. \$1.

RESEARCH MEMORANDUM ON SOCIAL ASPECTS OF HEALTH IN THE DEPRESSION. By Selwyn D. Collins and Clark Tibbitts. New York: Social Science Research Council. 1937. Pp. 192. \$1.

Discussion waxes hot regarding methods of providing adequate medical care. Here are three contributions providing light without heat. Each is a careful, factual analysis.

The reader who works in or near the field of medical care should be interested if not surprised to learn from Doctor Davis' book that more than \$500,000,000 a year is expended from tax funds for medical care. This includes care of the indigent, the chronic, those ill from tuberculosis and mental diseases and certain other special groups where a government responsibility has been acknowledged.

Executives and trustees of voluntary hospitals will be particularly interested in the chapter on tax payments to nongovernment hospitals. Doctor Davis presents ten principles of cooperation, worked out by the American Hospital Association and the American Public Welfare Association, which offer a promising basis for solving the difficult problems involved.

Doctor Bradbury makes the interesting computation of multiplying the Lee-Jones units, comprising adequate medical care, by the minimum fees for such units adopted by the Chicago Medical Society. On this basis, adequate physicians' care would cost annually \$63.53 per person for cure and \$12.22 per person for prevention, an astounding total of \$75.75! These figures, moreover, do not include public health services, dentistry, medicines or supplies.

Apparently there is little hope for adequate care of the population when provided on a fee-for-service basis.

The Collins-Tibbitts study makes no pretense of finality on the effects of the depression on health. Such a study cannot yet be made. Certain facts, however, are well established. "The poor have more sickness than the well-to-do, and, in general, receive less medical care and live in an environment that is less desirable from the standpoint of health." But, "lack of income, itself, does not cause illness; the true causes, insofar as their origin is social, appear to be insufficient and improper diet, poor housing, hazardous working conditions, inadequate clothing, and other factors closely related to income."

Each of these studies deserves careful analysis by administrators as well as physicians.—ALDEN B. MILLS.

MATERNAL DEATHS—THE WAYS TO PREVENTION. By Iago Galdston, M.D. New York: The Commonwealth Fund, 1937. Pp. 115.

A total 1,343 of 2,041 maternal deaths occurring during the period of the New York City study (1930-1932) were preventable. This and other like reports are the basis of this volume. Doctor Galdston analyzes the facts and places criticism where criticism is due. Economics, physicians, hospitals and the public are all held responsible. Hospital administrators should discuss this volume with the heads of their obstetric departments and prepare a list to whom the volume might be distributed.—ROBIN C. BUEKLI, M.D.

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